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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2680

CERTIFICATE OF DEATH

Reg. Dist. No.

02661

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 35yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pleasant Hill Road		e. STREET ADDRESS Pleasant Hill Road	
3. NAME OF DECEASED (Type or print) First Benjamin Middle J. Allison Last		4. DATE OF DEATH Month March Day 31 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1878
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener		11b. KIND OF BUSINESS OR INDUSTRY Maryland	
12. BIRTHPLACE (State or foreign country) U.S.		13. CITIZEN OF WHAT COUNTRY? U.S.	
14. FATHER'S NAME Franklin D. Allison		15. MOTHER'S MAIDEN NAME Isabelle Henry	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. INFORMANT Louis F. Sisson, 1603 Providence Road, Baltimore 4, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic Cardio-Vascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-19-54 , 19 61 , to 3-31-61 , that I last saw the deceased alive on March 30 , 19 61 , and that death occurred at 11A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Martin E. Strobel		DATE SIGNED 3-31-61	
PHYSICIAN'S NAME (Type) Martin E. Strobel, M.D.		ADDRESS (Street, city or town, state) 48 Main Street, Reisterstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/4/61	22c. NAME OF CEMETERY OR CREMATORY Fork Christian Cem.	22d. LOCATION (City, town, or county) (State) Fork, Balto Co. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		24a. REC'D BY REGISTRAR APR 4 '61	
ADDRESS 5305 Harford Road #14		24b. REGISTRAR'S SIGNATURE Arthur E. ...	

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STATE OF OHIO

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02662

2681

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House In The Pines				d. STREET ADDRESS 1909 Forest Park Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH MERRYMAN ANDERSON, Sr.				4. DATE OF DEATH Month Day Year March 23 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1879		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales		10b. KIND OF BUSINESS OR INDUSTRY Produce		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Horace A. Anderson				14. MOTHER'S MAIDEN NAME Mary XXXXX Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-32-4416		INFORMANT Address Daisy E. Anderson-1909 Forest Park Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Mar. 7, 1961	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 17, 1949 to March 23, 1961 , that I last saw the deceased alive on March 22, 1961 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Abraham B. Hurwitz				ADDRESS (Street, city or town, state) DATE SIGNED M.D. 3403 Garrison Blvd., Balto, Md. 3/23/61			
PHYSICIAN'S NAME (Type) Abraham B. Hurwitz, M.D.				3403 Garrison Boulevard			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/25/1961		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost				ADDRESS Ellsworth Armacost-4600 Liberty Hgts. Ave.		24a. REC'D BY REGISTRAR DATE MAR 27 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED BY THE DIRECTOR, FBI, WASHINGTON, D.C.

DATE: 10/10/50

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 10/10/50

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 10/10/50

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 10/10/50

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2682

02663

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				c. LENGTH OF STAY IN 1b 2 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5522 Selma Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nina M. Middle Appy Last Appy				4. DATE OF DEATH Month March Day 29 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 29, 1914	
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		11. IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress				10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Marie Grimes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO. 212-30-4134		17. INFORMANT Jesse M. Appy Address 5522 Selma Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma Cervix DUE TO (b) with Metastases to spine Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs 6 mo.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from Dec 1960 to Mar 29, 1961 , that (I) (we) last saw the deceased alive on Mar 29, 1961 , and that death occurred at 2:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE A. Bradley Daugharthy 22c. PHYSICIAN'S NAME (Type) A. Bradley Daugharthy				22b. DATE SIGNED 3-30-61		22d. ADDRESS 1264 Francis Ave., Balto. 27, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/1/61		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City, town, or county) (State) Dorsey, Howard, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ambrose, Inc. 1328 Sulphur Spring Rd.				25a. REC'D BY REGISTRAR DATE APR 3 '61		25b. REGISTRAR'S SIGNATURE <i>Walter L. Finner</i>	

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Journal of Management Inquiry 20(4) 409-424

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2683

02664

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS Mills</u> c. LENGTH OF STAY IN 1b <u>22 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood State Training School</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>100 So. Carlton</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHARLES SHERIDAN ARMSTRONG</u> First Middle Last 5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>FEB 12, 1956</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>6</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Charles Eugene Armstrong</u> 14. MOTHER'S MAIDEN NAME <u>Evelyn Louise Tasker</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Chart of Rosewood</u> Address <u>Owings Mills, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of food</u> 753.1 DUE TO (b) <u>General debility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Severe microcephaly</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>mental retardation</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 19 <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>May 26, 1961</u> , to <u>Mar. 20, 1961</u> , that (I) (we) last saw the deceased alive on <u>Mar. 20, 1961</u> , and that death occurred <u>3:45 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Olive Reid Harris</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Olive Reid Harris</u>				22b. ADDRESS <u>Owings Mills, Maryland</u> 22d. DATE <u>MAR 27 '61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Fun 23 - 41</u>		23b. DATE THEREOF <u>Mar 23 - 41</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Amaboy Burial</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Howell</u> ADDRESS <u>Pikemill</u>		25a. REC'D BY REGISTRAR <u>MAR 27 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

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May 22 1951

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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2684
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
02665

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>3V01-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>		c. LENGTH OF STAY IN 1b <u>9 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MASONIC HOME</u>		d. STREET ADDRESS <u>2003 RAMSEY ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH M ARNOLD</u>		4. DATE OF DEATH Month Day Year <u>MAR 9 1961</u>	
5. SEX <u>FE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-9-1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN GATER MAN</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH OLD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-03-0008</u>	
17. INFORMANT <u>Frank L. Smith Jr.</u> Address <u>Cockeysville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardio Vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Accident</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-18</u> 19 <u>52</u> , to <u>3-9</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3-9</u> 19 <u>61</u> , and that death occurred at <u>7:30 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Walter T. Kees</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>3/9/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER T. KEES</u>		22d. ADDRESS <u>COCKEYSVILLE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-13-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm. Cook, Inc., 1217 St. Paul Street</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 13 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

0280

CENTRAL OF MARYLAND

4302

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death of the deceased. The law also requires that the death certificate be filled in by the attending physician and completed by the funeral director. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESIDENT STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2685

02666

1. NAME OF DECEASED (Type or Print) VERA BADINGER		2. DATE OF DEATH March 12 1961	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5 Island Pt Road, Baltimore 24		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore 24 (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 5 Island Point Road	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH DEC 6 1960
9. AGE (In years last birthday) 37		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10. B. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Maryland (City)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBERT Badinger		14. MOTHER'S MAIDEN NAME EMILY CURRY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Parents
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asthma, etc. It means the disease, injury or complication which caused death) Hydrocephalus		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Meningocele			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
21. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		21A. DATE OF OPERATION	21B. CONDITION FOR WHICH OPERATION WAS PERFORMED
22. I certify that (I) (this hospital) attended the deceased from Birth to Dec 19 61 and that in (my) (our) opinion death occurred on March 7 19 61 at 5:30 am , from the causes and on the date stated above.			
23A. SIGNATURE Andrew B. Richards ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23B. ADDRESS Johns Hopkins Hospital	23C. DATE SIGNED March 13
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Mar 15 - 61	24C. NAME OF CEMETERY OR CREMATORY St. Carmel Cemetery	24D. LOCATION (City, town, or county) (State) Balto Md
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1961		25B. NAME OF REGISTRAR Arthur L. Michael	
		25C. FUNERAL DIRECTOR Joseph M. Connolly	

11. CERTIFICATION

VR 15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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2686
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
02667

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SHADY NOOK NURSING HOME</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>1500 Frederick Rd</u>	
3. NAME OF DECEASED (Type or print) <u>RICHARD PRICE</u> 4. DATE OF DEATH <u>MARCH 21 1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> D. VORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 26, 1871</u> 9. in years <u>89</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumber MFG.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u> 11. BIRTHPLACE (County & State, or foreign country) <u>US</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>ARTHUR P. BAER</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Price</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>William Vogdes 1001 W. Calvert St. Balt-2</u> 17. INFORMANT <u>1001 W. Calvert St. Balt-2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>4/1/1</u> DUE TO (c) <u>Chronic myeloid leukemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Chronic myeloid leukemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1949</u> to <u>March 21 1961</u> , that (I) (we) last saw the deceased alive on <u>March 21 1961</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John A. Nesbitt Jr.</u> 22c. PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>1118 St Paul St. Balt. 2. Md</u>	
22b. DATE SIGNED <u>3-23-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>MARCH 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LOUNDON PARK</u>	
23d. LOCATION (City, town or county) <u>BALTIMORE</u> (State) <u>MD</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>William A. Nesbitt Jr.</u> ADDRESS <u>28</u>	
25a. REC'D BY REGISTRAR <u>MAR 27 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2687

02668

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Woodstock				c. LENGTH OF STAY IN 1b Woodstock			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hernwood Road				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mr. Nickolas Baker				4. DATE OF DEATH Month Day Year March 8, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sep't. 1, 1862	
9. AGE (In years lost birthday) 98 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown Edith Cannon Haddaway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO (If yes, give war or dates of service) None		17. INFORMANT Address Mrs. Edith G. Baker, Hernwood Rd. Woodstock, P.O.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Hypertensive C.V. disease - renal insufficiency & peripheral edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 10 years							INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN 2 1960 to MAR 8 1961 , that (I) last saw the deceased alive on MAR 8 1961 and that death occurred at 12 noon from the causes and on the date stated above.							
22a. SIGNATURE Thomas E. Wheeler M.D.				22b. ADDRESS 3601 Clifmar Rd. Balto. 7, Md.		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-10-1961		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION (City, town, or county) (State) Randallstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Spring Byers				25a. REC'D BY REGISTRAR MAR 13 '61		25b. REGISTRAR'S SIGNATURE William L. Kline	

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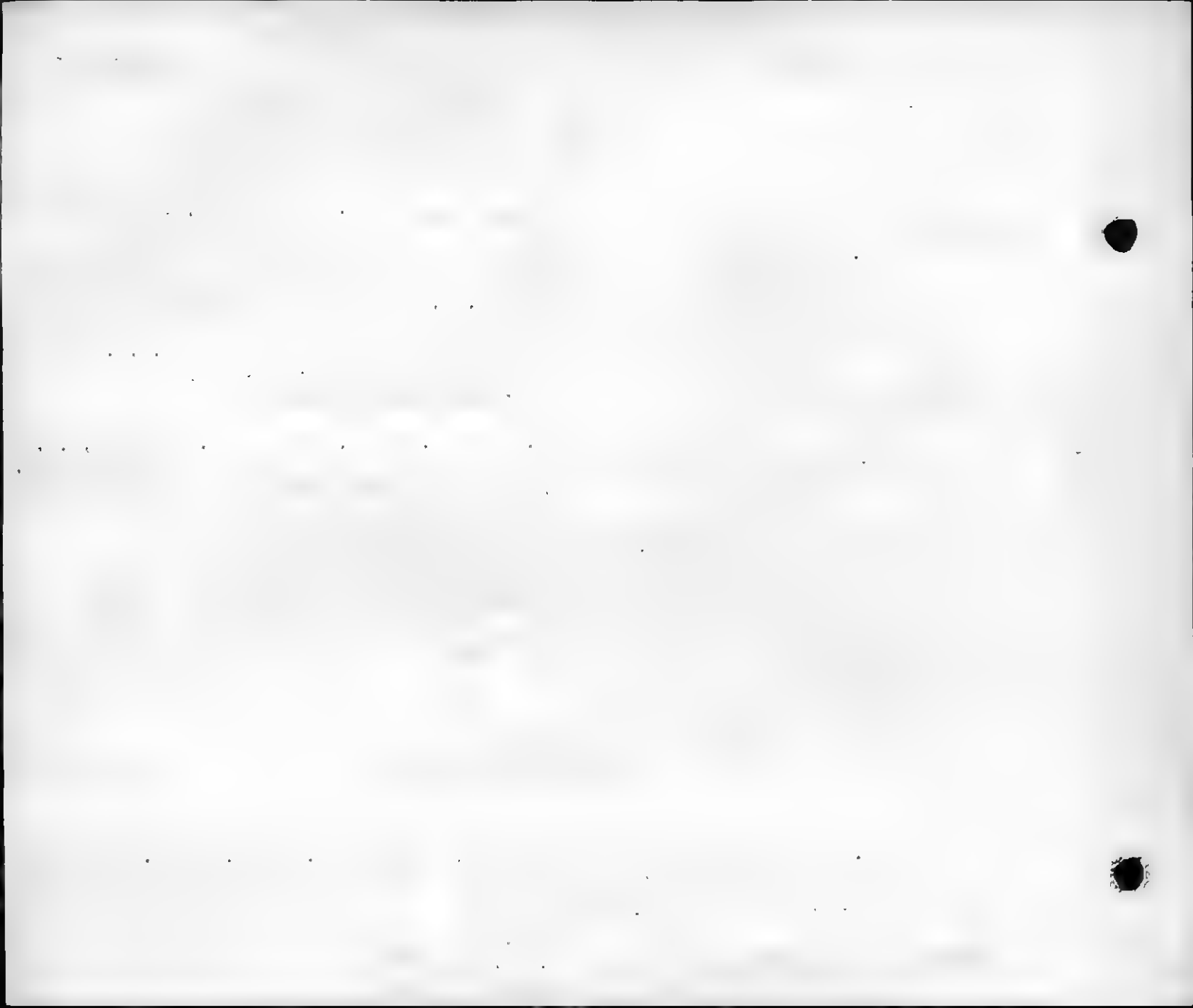
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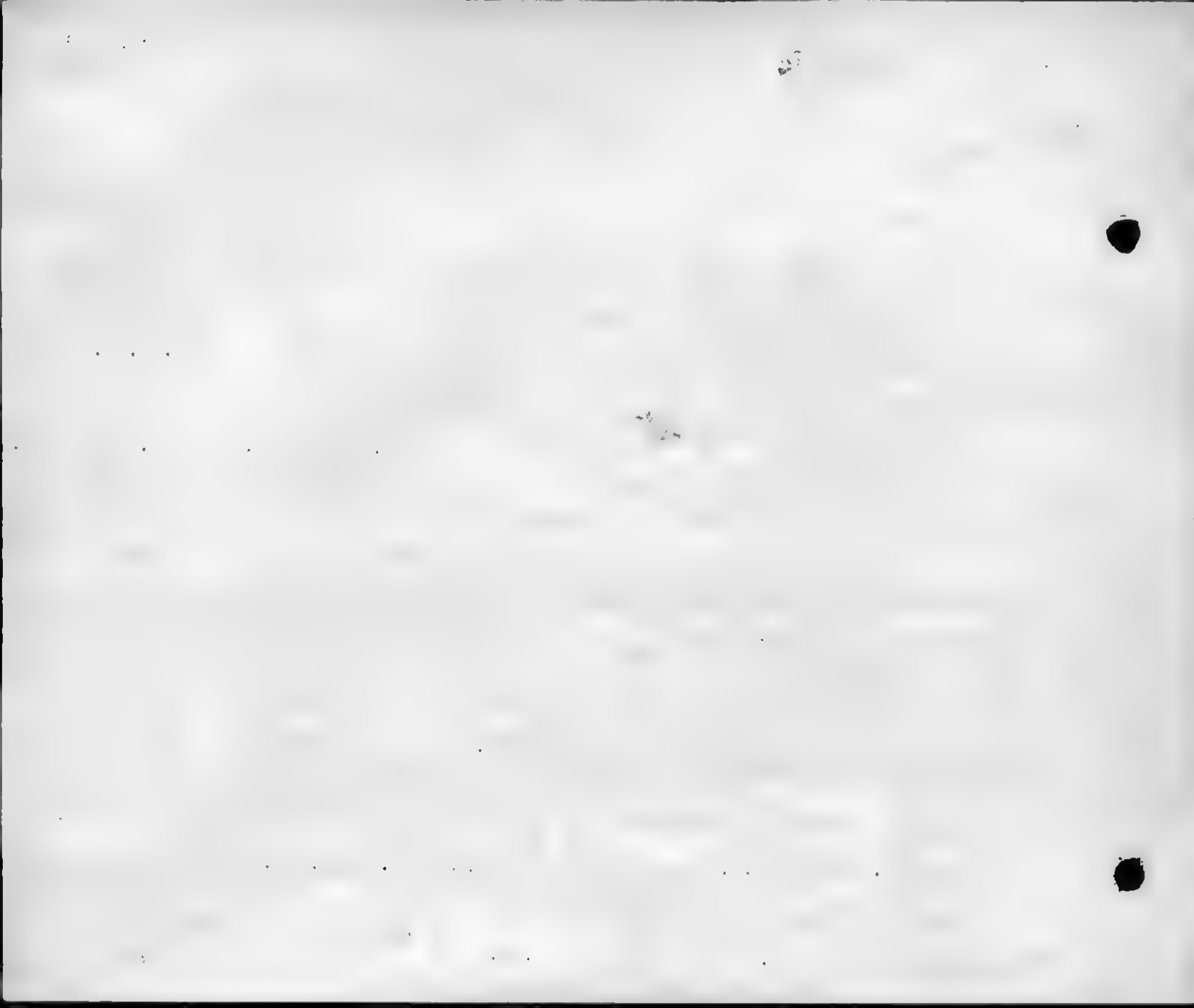
may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2688 Item 23b, Film 3285 5/27/61 iwr											
CERTIFICATE OF DEATH											
02669											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 132 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 306 S. Woodyear Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) GUY First Middle Last BARRETTE						4. DATE OF DEATH Month Day Year March 20 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1888		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed Soldier				10b. KIND OF BUSINESS OR INDUSTRY Army		11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Joseph Barrette						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I						16. SOCIAL SECURITY NO. 219-32-3560					
17. INFORMAT Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART ATTACK DUE TO MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)											
INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 1 HOUR UNKNOWN											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
PULMONARY EMPHYSEMA. GOUT											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that Xi (this hospital) attended the deceased from Nov. 8 1960 to March 20 1961 , that (X) (we) last saw the deceased alive on March 20 1961 , and that death occurred at 9:45 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Thomas F. Garace M.D.											
22b. DATE SIGNED 3/20/61											
22c. PHYSICIAN'S NAME (Type) THOMAS F. GARACE, M.D.											
22d. ADDRESS VAH, BALTO. 18, MD., FT. HOWARD DIVISION											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF Mar. 23, 1961											
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL											
23d. LOCATION (City, town or county) (State) BALTIMORE MARYLAND											
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Farace, 712 E. North Avenue, Balto. Md.											
25a. MAR BY REGISTRAR MAR 22 1961											
25b. REGISTRAR'S SIGNATURE Arthur S. Kline											



may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2689

02670

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>1st</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>				d. STREET ADDRESS <u>Bayside, Long Island</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FREDERICK</u> First Middle Last				4. DATE OF DEATH <u>March</u> Month Day Year <u>9</u> 19 <u>61</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 16, 1863</u> 9. AGE (In years last birthday) <u>97</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Allen Falls Cement Co</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Springfield, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Bassinger</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Ely</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>682-14-6728</u>		17. INFORMANT <u>Family Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>450.0</u> IMMEDIATE CAUSE (a) <u>franch pneumonia, bilateral</u> DUE TO (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>advanced age - feebleness</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 11</u> , 19 <u>61</u> , to <u>March 9</u> , 19 <u>61</u> , that (I) (we) lost saw the deceased alive on <u>March 9</u> , 19 <u>61</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>James R. Jordan</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-9-61</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal/Burial Mar. 11, 1961</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>St. Charles Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Pinehan, Long Island, N.Y.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Town, Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

(I)

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G284 4/4/61 iwk

CERTIFICATE OF DEATH

Item 3, Film G-203 3/20/61.cac

Reg. Dist. No.

02671

2690

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hereford				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hereford Rd., Hereford, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Louvinia Blackston H. Batson				4. DATE OF DEATH Month March Day 23 Year 1961			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1913	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months 48 Days 0 Hours 0 Min 0	IF UNDER 24 HRS. Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Webly Greene				14. MOTHER'S MAIDEN NAME Henreitta Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO 721-12-3684			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemias DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH 3 Yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) York Rd	
20f. (City or town) Parkton, Md				(County) (State)			
21. I certify that I attended the deceased from 1-20-61 to 3-23-61 , that I last saw the deceased alive on 3-23-61 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Parkton, Md DATE SIGNED _____							
ACTUAL SIGNATURE C. Herbert Mueller Jr. M.D.				PHYSICIAN'S NAME (Type) C. Herbert Mueller Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/27/61		22c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	
22d. LOCATION (City, town, or county) Arbutus				(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE William A. Jackson Funeral Home Inc.				ADDRESS Arbutus		24a. REC'D BY REGISTRAR DATE MAR 28 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Howard							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

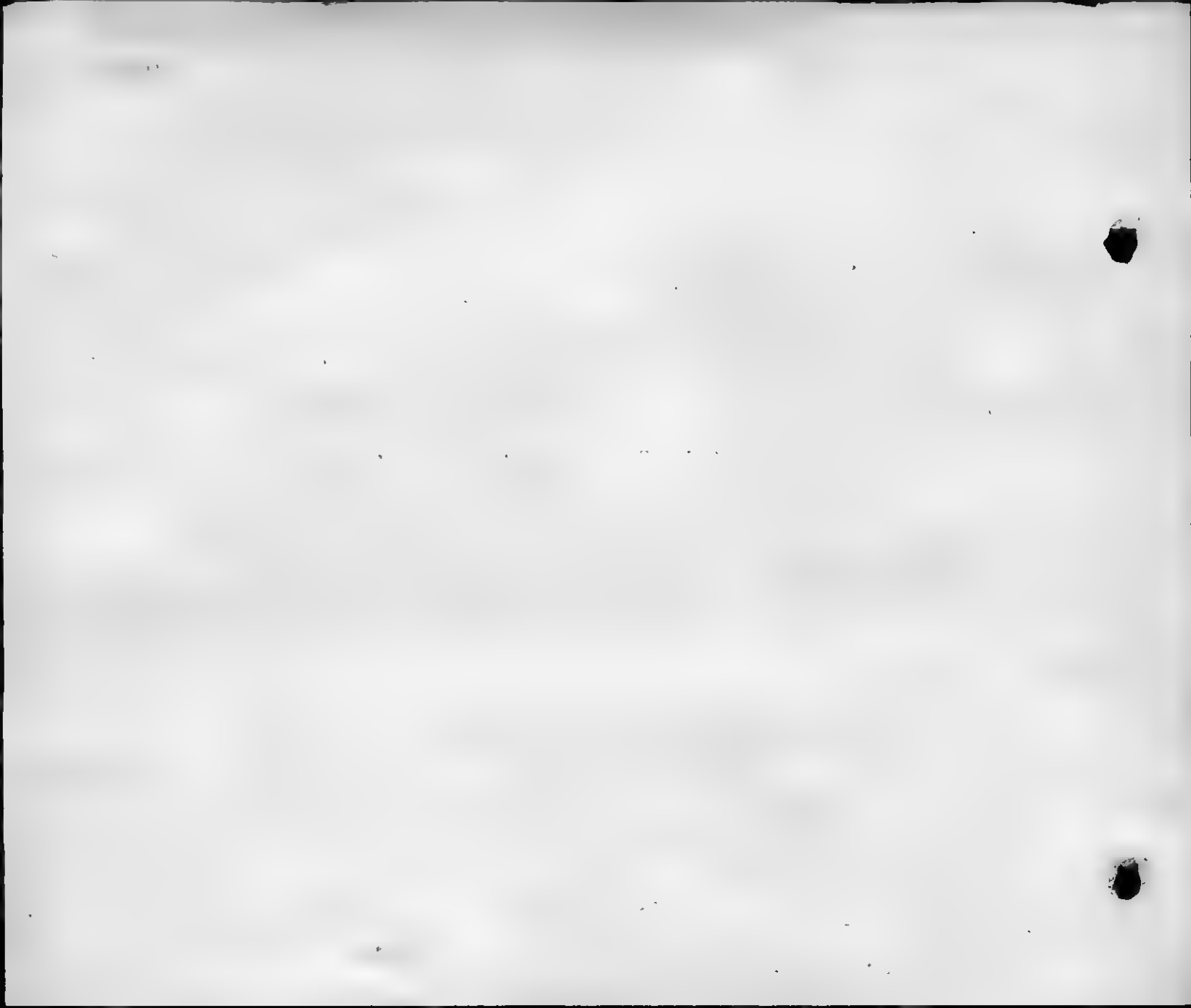
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2691

02672

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7924 Berk Lane</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>7924 Berk Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. Henry Berk</u> e. SEX <u>male</u> f. COLOR OR RACE <u>white</u> g. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> h. DATE OF BIRTH <u>July 2, 1889</u> i. AGE (in years if under 1 year, last birthday) <u>71</u> yrs. <u>March 2nd</u> 19 <u>61</u> j. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Chipper and Corker</u> k. FATHER'S NAME <u>Karl Berk</u> l. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>213-09-2495</u> m. SOCIAL SECURITY NO. <u>213-09-2495</u> n. INFORMANT <u>Mrs. Hilda E. Berk</u> o. ADDRESS <u>same</u>		4. DATE OF DEATH a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. DATE OF BIRTH <u>July 2, 1889</u> c. AGE (in years if under 1 year, last birthday) <u>71</u> yrs. <u>March 2nd</u> 19 <u>61</u> d. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co. Maryland</u> e. CITIZEN OF WHAT COUNTRY? <u>USA</u> f. MOTHER'S MAIDEN NAME <u>Katherine Stadder</u>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of colon</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Adenocarcinoma of colon</u> (c) <u>Pulmonary emphysema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>same</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>4</u> p.m. <u>16</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ridge Rd. Baltimore G. Md.</u> 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1958</u> to <u>March, 1961</u> , that (I) (we) last saw the deceased alive on <u>2/16</u> 1961 , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Samuel Stern</u> 22c. PHYSICIAN'S NAME (Type) <u>SAMUEL STERN</u> 22d. ADDRESS <u>Ridge Rd. Baltimore G. Md.</u> 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED		23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial</u> <u>3/5/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Lion Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Stemmers Run, Balto Co Md.</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u> 25a. REC'D BY REGISTRAR <u>MAR 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2692

CERTIFICATE OF DEATH

02673

1. PLACE OF DEATH
1. NAME OF DECEASED (Type or Print) **BENJAMIN BERMAN**
2. DATE OF DEATH **3/12/61**

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

Baltimore County
6907 Delair Road
Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE **Md.** B. COUNTY **Baltimore**

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

6907 Delair Road

5. SEX **male**

6. COLOR OR RACE **white**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **married**

8. DATE OF BIRTH **10/1/1907**

9. AGE (in years last birthday) **73**

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours: Min.

10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Custom Tailor

10B. KIND OF BUSINESS OR INDUSTRY
own business

11. BIRTHPLACE (State or foreign country)
Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

3. FATHER'S NAME

Isaac Berman

14. MOTHER'S MAIDEN NAME

unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Minnie Bensel Berman, wife, above

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒

22. I certify that (I) (this hospital) attended the deceased from **3/2** to **3/9** 19**61** that (I) (we) last saw the deceased alive on **3/9** 19**61** and that in (my) (our) opinion death occurred at **3A** m., from the causes and on the date stated above.

23A. SIGNATURE

A. H. Hornstein

M. D.

23B. ADDRESS

204 E. Biddle St

23C. DATE SIGNED

3/14/61

ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/16/61

24C. NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

5

25B. NAME OF REGISTRAR

William S. Hargrave

25C. FUNERAL DIRECTOR

Charles J. Schimunek Funeral Home
1015 S. Lane

ADDRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



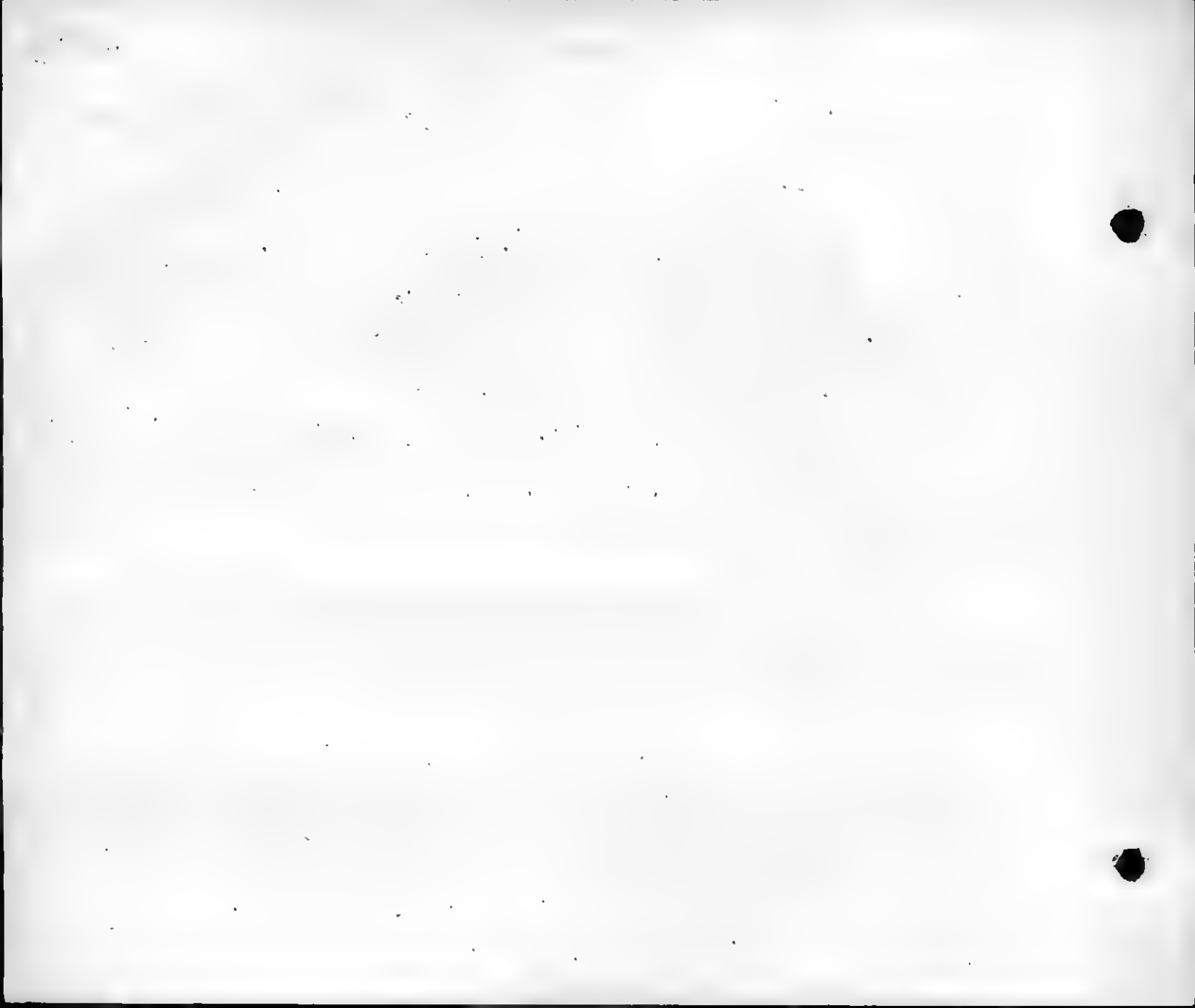
2693

CERTIFICATE OF DEATH

Reg. Dist. No. 02674

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6651 Chippewa Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis</u> First <u>Better</u> Middle <u>Ann</u> Last		4. DATE OF DEATH <u>March 4</u> 19 <u>61</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 25, 1905</u> 9. AGE (In years last birthday) <u>55</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	11. BIRTHPLACE (State or foreign country) <u>Austria</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Salomon Better</u>	
14. MOTHER'S MAIDEN NAME <u>Esther ?</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>26-32-8105</u>		17. INFORMANT <u>Mrs Anna Better - 6651 Chippewa Dr</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Dec 16</u> 19 <u>58</u> , to <u>March 4, 1961</u> that I last saw the deceased alive on <u>March 4, 1961</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Benjamin Berdann</u> M.D.		ADDRESS (Street, city or town, state) <u>7809 Liberty Rd Baltimore, Md</u> DATE SIGNED <u>March 4, 1961</u>	
PHYSICIAN'S NAME (Type) <u>BENJAMIN BERDANN</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Mar 5/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Chapel Ameno</u> 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Salomon + Bros</u> ADDRESS <u>2600 Reist Road</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 7 '61</u> 24b. REGISTRAR'S SIGNATURE <u>S. S. K...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2694 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02675

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Victory Villa (20)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Victory Villa (20)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>68 Traverse Ave.</u>		d. STREET ADDRESS <u>6 Sli...stream Court</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>RAY</u> Last <u>PHILIPS</u>		4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 22, 1948</u>
9. AGE (In years last birthday) <u>12</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Carl Billings</u>	
14. MOTHER'S MAIDEN NAME <u>Marjorie Dixon</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Carl Billings</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>736.4</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Same</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Accidentally entangled in rope while Subject was climbing.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C Collins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/16/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hartsell Funeral Home</u>
22d. LOCATION (City, town, or county) <u>Concord, North Carolina</u>		(State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James A. Prizdzinski</u>		ADDRESS <u>1407 Eastern Ave. (21)</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 20 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

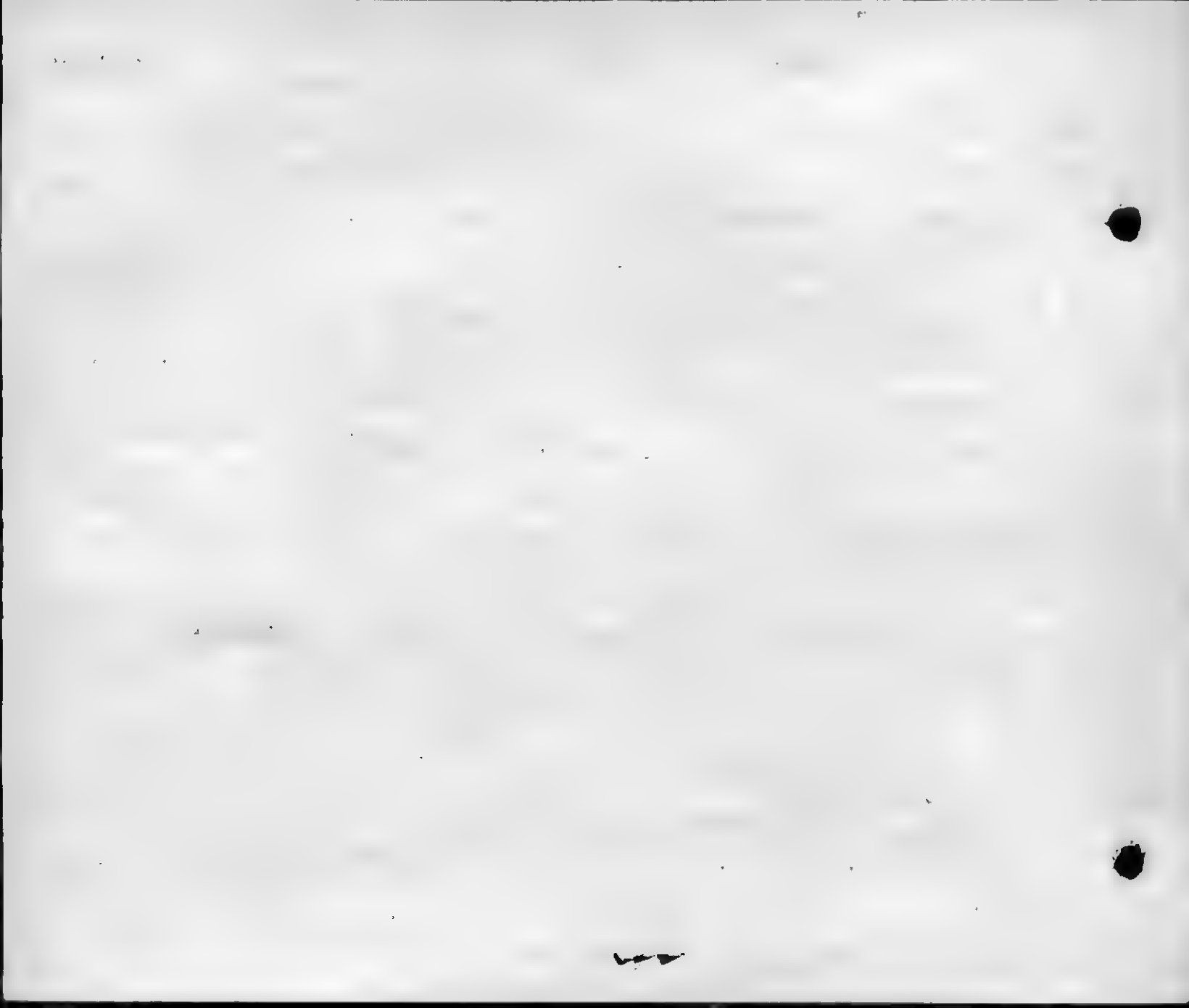
VR A15 (4)
15M 9/60

2695

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02676

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 39 Days Glen Burnie, (Maryland)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS West Drive Box 290W, Rt. 1, Silver Sands,	
3. NAME OF DECEASED (Type or print) JOHN A. BISESI		4. DATE OF DEATH March 16 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 23, 1893	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commission Merchant		10b. KIND OF BUSINESS OR INDUSTRY Merchant House	
13. FATHER'S NAME Phillips Bisesi		14. MOTHER'S MAIDEN NAME Anna Catanzio	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not or unknown) Yes WW I		16. SOCIAL SECURITY NO. 220-03-1389	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION		18. CITIZEN OF WHAT COUNTRY U. S. A.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF LUNG, PRIMARY SITE X UNKNOWN UNKNOWN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) CHRONIC PULMONARY EMPHYSEMA Operation: 4/18/60 Biopsy of tumor mass, left side of neck: Carcinoma		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Findings: Metastatic Anaplastic	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from February 5, 1961 to March 16, 1961, that (b) (we) last saw the deceased alive on March 16, 1961, and that death occurred at 8:25 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan		22b. DATE SIGNED 3/16/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/20/61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE JOHN F. D'ANNY, INC.		25a. REC'D BY REGISTRAR MAR 21 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2696 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02677

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u>		b. COUNTY <u>BALTO CITY</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3104 BAYBRIAR RD.</u>		d. STREET ADDRESS <u>3104 BAYBRIAR RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BRENDA</u>		First Middle Last <u>GAIL BOARDWINE</u>		4. DATE OF DEATH Month Day Year <u>MARCH 14 1961</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>20 FEB 1961</u>		9. AGE (in years last birthday) <u>22</u>		IF UNDER 1 YEAR Months Day Hours Min. <u>22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND (City)</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ABRAM BOARDWINE</u>		14. MOTHER'S MAIDEN NAME <u>MELVA KESTNER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MELVA K. BOARDWINE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHITIS</u> DUE TO (b) <u>PNEUMONIA - BRONCHIAL -</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>NO INJURY</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>		20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. <u>M. B. DAVIS, MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS, MD</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <u>DUNDALK, MD</u>		DATE SIGNED <u>3/14/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-17-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>RIVER BRIDGE CEMETERY</u>	
22d. LOCATION (City, town, or country) <u>HOLTON WASHINGTON CITY, VA</u>		22e. (State) <u>VA</u>		22f. REC'D BY REGISTRAR <u>—</u>	
22g. REGISTRAR'S SIGNATURE <u>Arthur L. Finner</u>		DATE <u>MAR 15 '61</u>		22h. FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME</u>	
22i. ADDRESS <u>2112 DUNDALK AVE</u>		22j. (City or town) <u>DUNDALK</u>		22k. (State) <u>MD</u>	

$$2638304 \times \sqrt{4}$$



CERTIFICATE OF DEATH

Reg. Dist. No.

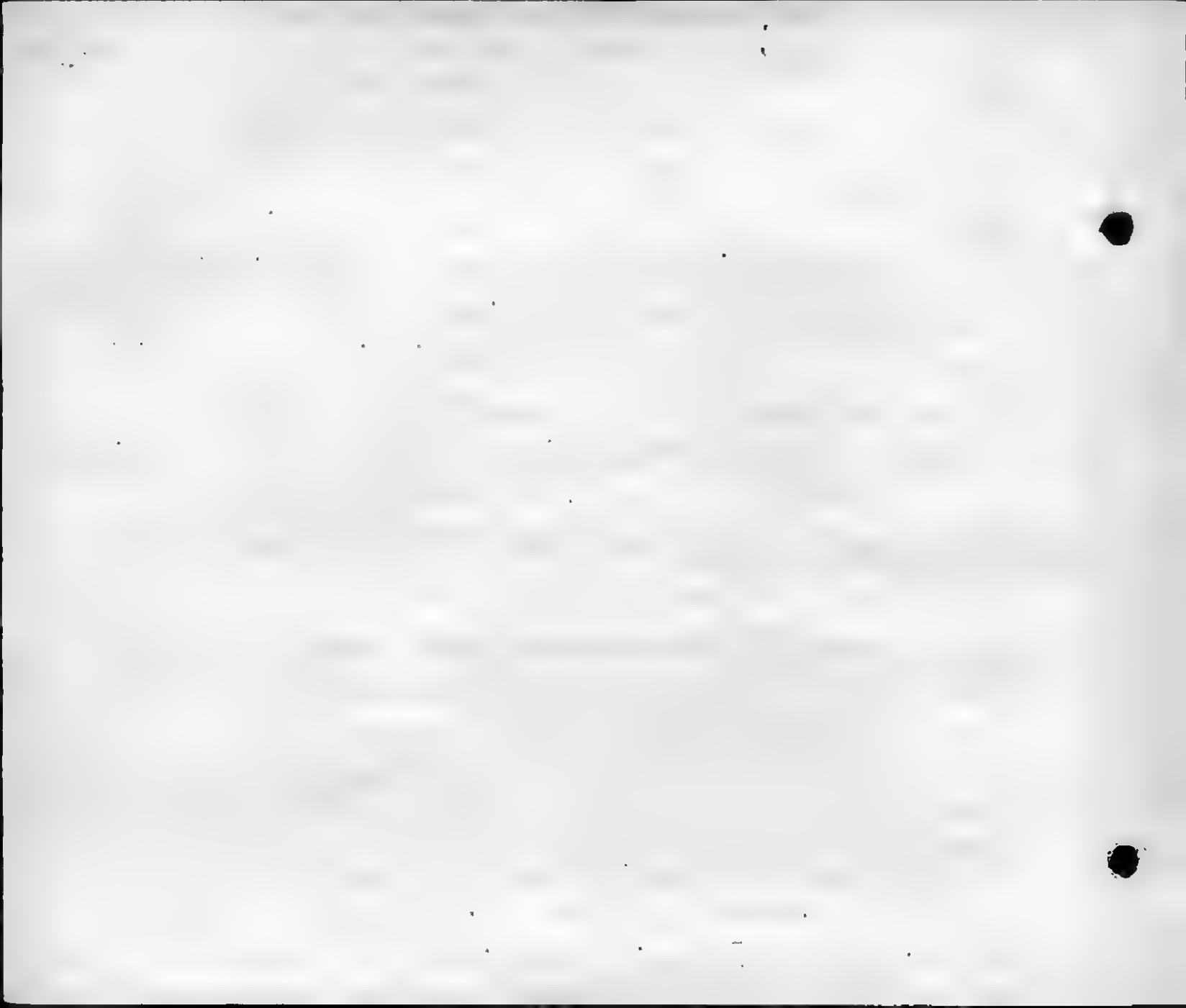
02678

2697

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Manor Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Laura M. Borton</u>				4. DATE OF DEATH Month Day Year <u>Mar. 16, 1961</u> 19			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1, 1869</u>	9. AGE (In years last birthday) <u>91</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Phil. Pa.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Zachary Faunce</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ella Jackaway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>199-03-9367</u>		17. INFORMANT Address <u>J. Howard Borton-213 Westowne Rd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY ARTERY DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Genescler arteriosclerosis -</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>JAN 1961</u> , to <u>MARCH 16, 1961</u> , that I last saw the deceased alive on <u>MARCH 14, 1961</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6014 EDWARDSIN, BALTIMORE MD 21214</u> DATE SIGNED <u>APR 3 1961</u>							
ACTUAL SIGNATURE <u>J. Nelson McKay</u>		M.D. <u>6014 EDWARDSIN, BALTIMORE MD 21214</u>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
<u>Burial</u>	<u>Mar. 20, 1961</u>	<u>Harleigh Cem.</u>		<u>Camden New Jersey</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Miller Inc.</u>		ADDRESS <u>-2431 E. Oliver St.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 22 '61</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2698

Reg. Dist. **02679**

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b 8 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1721 LESLIE RD.		d. STREET ADDRESS 1721 LESLIE RD	
3. NAME OF DECEASED (Type or print) First Middle Last LOUISA E. BRADFORD		4. DATE OF DEATH Month Day Year MAR. 10 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 28, 1884
9. AGE (In years lost birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBERT OMPTEDA		14. MOTHER'S MAIDEN NAME (MAIDEN NAME) ELIZABETH (NOT KNOWN)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address J.S. BRADFORD 1903 QUEENS WAY (22)			
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive Cardio Vascular Disease (Fibrillation) DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan - 1950 to March 10, 1961 , that I last saw the deceased alive on March 8, 1961 , and that death occurred at 10:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis Krause		ADDRESS (Street, city or town, state) 11 E. CHASE ST. BALTO. MD.	
PHYSICIAN'S NAME (Type) LOUIS KRAUSE		DATE SIGNED 3/13/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/14/61	22c. NAME OF CEMETERY OR CREMATORY MT. CARMEL	22d. LOCATION (City, town, or county) (State) BALTO. MD.
23. FUNERAL DIRECTOR'S SIGNATURE G.W. Hoffmann		ADDRESS 3218 HUDSON ST.	
24a. REC'D BY REGISTRAR MAR 14 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2699

CERTIFICATE OF DEATH

Reg. Dist. 02680

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>7 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3208 McJANE WAY</u>		d. STREET ADDRESS <u>3208 McJANE WAY</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARETHA BRANDENBURG</u>		4. DATE OF DEATH Month Day Year <u>MARCH 28 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 15, 1870</u>
9. AGE (In years lost birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>GERMANY</u>	
13. FATHER'S NAME <u>- GARBER</u>		14. MOTHER'S MAIDEN NAME <u>-</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>FRIEDA NIEBUHR 3208 McJANE WAY</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (b) <u>10 YRS</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>57</u> , to <u>28 March 1961</u> , that I last saw the deceased alive on <u>28 March 1961</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Baermann</u> M.D.		ADDRESS (Street, city or town, state) <u>1000 E. FREDERICK ST. BALTIMORE MD.</u>	
PHYSICIAN'S NAME (Type) <u>W. Baermann</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>MAR 31, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOMES, DUNDALK, MD.</u>		ADDRESS <u>4400 E. FREDERICK ST. BALTIMORE MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 5 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

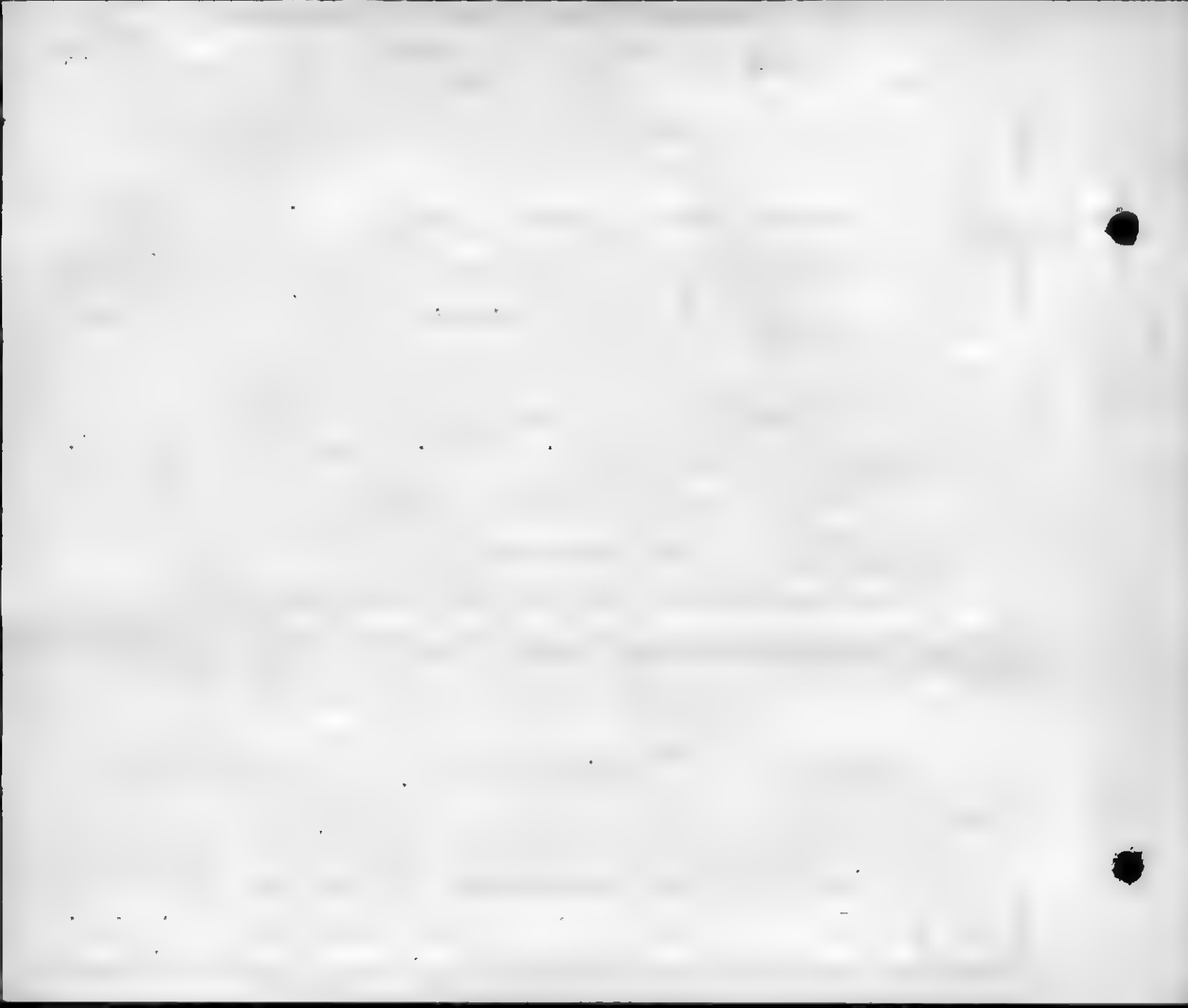
2700

CERTIFICATE OF DEATH

Reg. Dist. No.

02681

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ivy Hall Nursing Home</u>		e. STREET ADDRESS <u>404 Elmwood Rd.</u>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LYDIA</u> Middle <u>BRESNICK</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 15, 1895</u>
9. AGE (In years last birthday) yrs. <u>65</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William Gellert</u>		14. MOTHER'S MAIDEN NAME <u>Emelia Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Gilbert V. Bresnick</u>		Address <u>6104 Springwood Ct. 6</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma - primary site undetermined</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>- Carcinoma - widespread metastases.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rickettsia Glanders - left foot.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 22, 1961</u> , to <u>March 1, 1961</u> , that I last saw the deceased alive on <u>March 1, 1961</u> , and that death occurred at <u>11 A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Wm. A. Rodgers</u> M.D. <u>815 Eastern Ave.</u> <u>3-1-61</u>			
PHYSICIAN'S NAME (Type) <u>Wm. A. Rodgers</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-4-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Zion Evan. Lutheran</u>	22d. LOCATION (City, town, or county) (State) <u>Stemmers Run, Balto. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 3 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/59

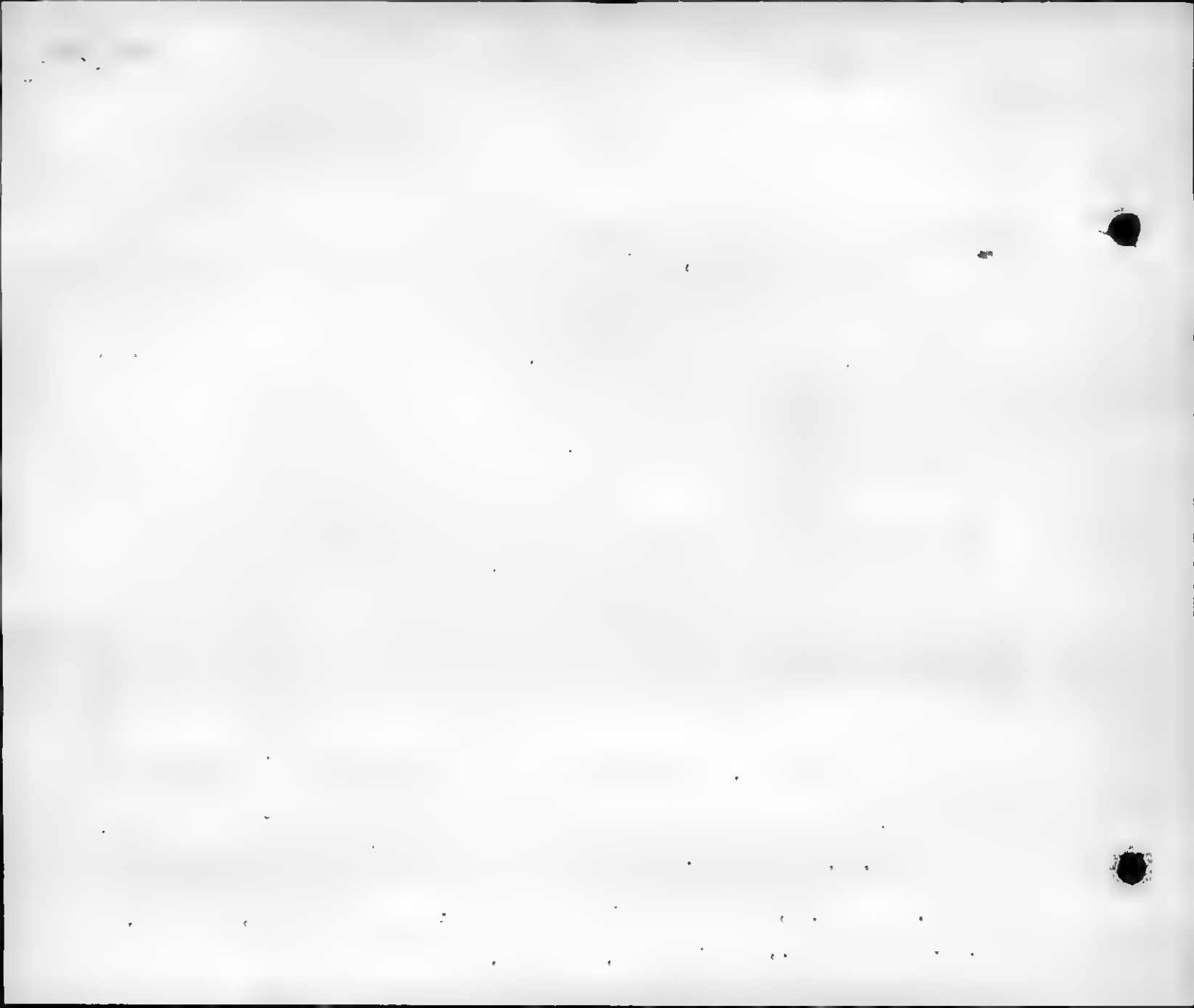
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2701

CERTIFICATE OF DEATH

02660

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Joseph's Normal Institute Ellicott City, Maryland	
f. STREET ADDRESS Beltsville, P.O. Ammdale, Pr. Geo. Co. Md.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Brother Sebastian, Dacius (Allgeier)		4. DATE OF DEATH March 31 19 61	
5 SEX male	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1889
9. AGE (In years last birthday) 71		IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police Brother Teacher		10b. KIND OF BUSINESS OR INDUSTRY Catholic Order of Christian Bros.	
11 BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Allgeier		14. MOTHER'S MAIDEN NAME Lita Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Bilateral hydronephrosis & urinary retention DUE TO (c) Benign prostatic hypertrophy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from March 28 1961 to Mar. 31 1961 that (I) (we) last saw the deceased alive on Mar. 31, 1961 and that death occurred at 625 P. M. from the causes and on the date stated above			
22a. SIGNATURE H. I. Cholmondeley		22b. DATE 4/1/61	
22c. PHYSICIAN'S NAME (Type) H. I. Cholmondeley		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 4, 1961	
23c. NAME OF CEMETERY OR CREMATORY Christian Brothers Cemetery		23d. LOCATION (City, town, or county) (State) Ammdale, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.,		25a. REC'D BY REGISTRAR DATE 4 '61	
ADDRESS Riverdale, Maryland.		25b. REGISTRAR'S SIGNATURE C. S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

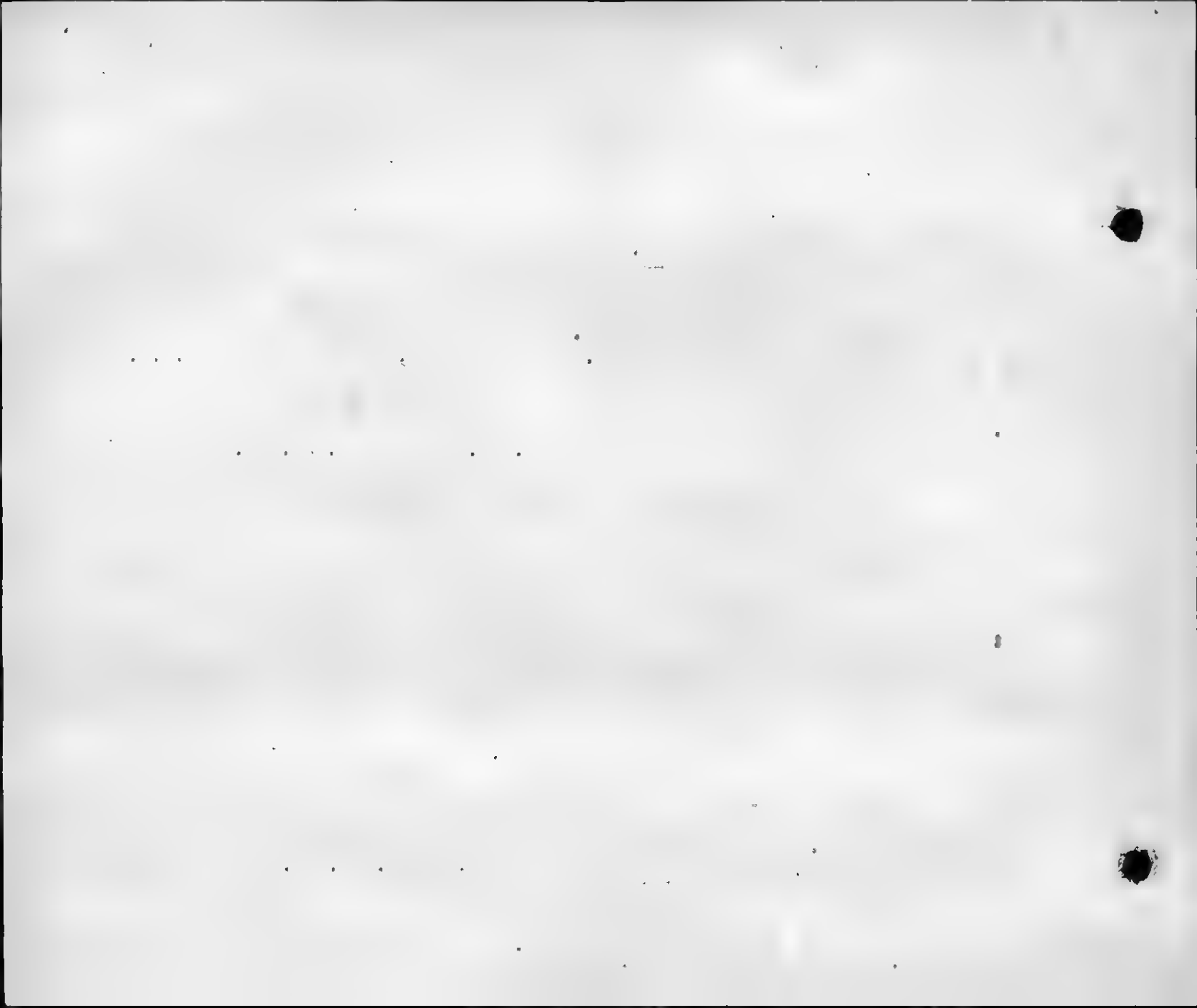
2702

02682

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN lb <u>30 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2820 Brighton Street</u>	
3. NAME OF DECEASED (Type or print) <u>STEPHEN B. BROWN</u> First Middle Last <u>Served As: STEPHEN B. BROWN</u>		4. DATE OF DEATH <u>MARCH 19 1961</u> Month Day Year	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/11/01</u> Year Month Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture Co.</u>		9. AGE (In years last birthday) <u>59</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Stephen Brown</u> 14. MOTHER'S MAIDEN NAME <u>Lucy Watts</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW II</u> 16. SOCIAL SECURITY NO. <u>WW II</u> 17. INFORMANT <u>Clin. Rec. VAH, Balto. Md. Ft. Howard Division</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE PULMONARY HEMORRHAGE</u> DUE TO <u>CARCINOMA LEFT LUNG WITH METASTASIS TO RIGHT LUNG</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>6 Months</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Collapsed Vertebra L-I</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <u>Feb. 17 1961</u> to <u>March 19 1961</u> , that (we) last saw the deceased alive on <u>March 19 1961</u> , and that death occurred at <u>7:40 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas F. Crahan</u> M.D.		22b. DATE SIGNED <u>3/20/61</u>	
22c. PHYSICIAN NAME (Type) <u>THOMAS F. CRAHAN, M.D.</u>		22d. ADDRESS <u>VAH, Balto. Md. Ft. Howard Division</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-23-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles G. Cooper</u> ADDRESS <u>510 Carrollton Ave. Baltimore, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 24 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles G. Cooper</u>		25c. DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

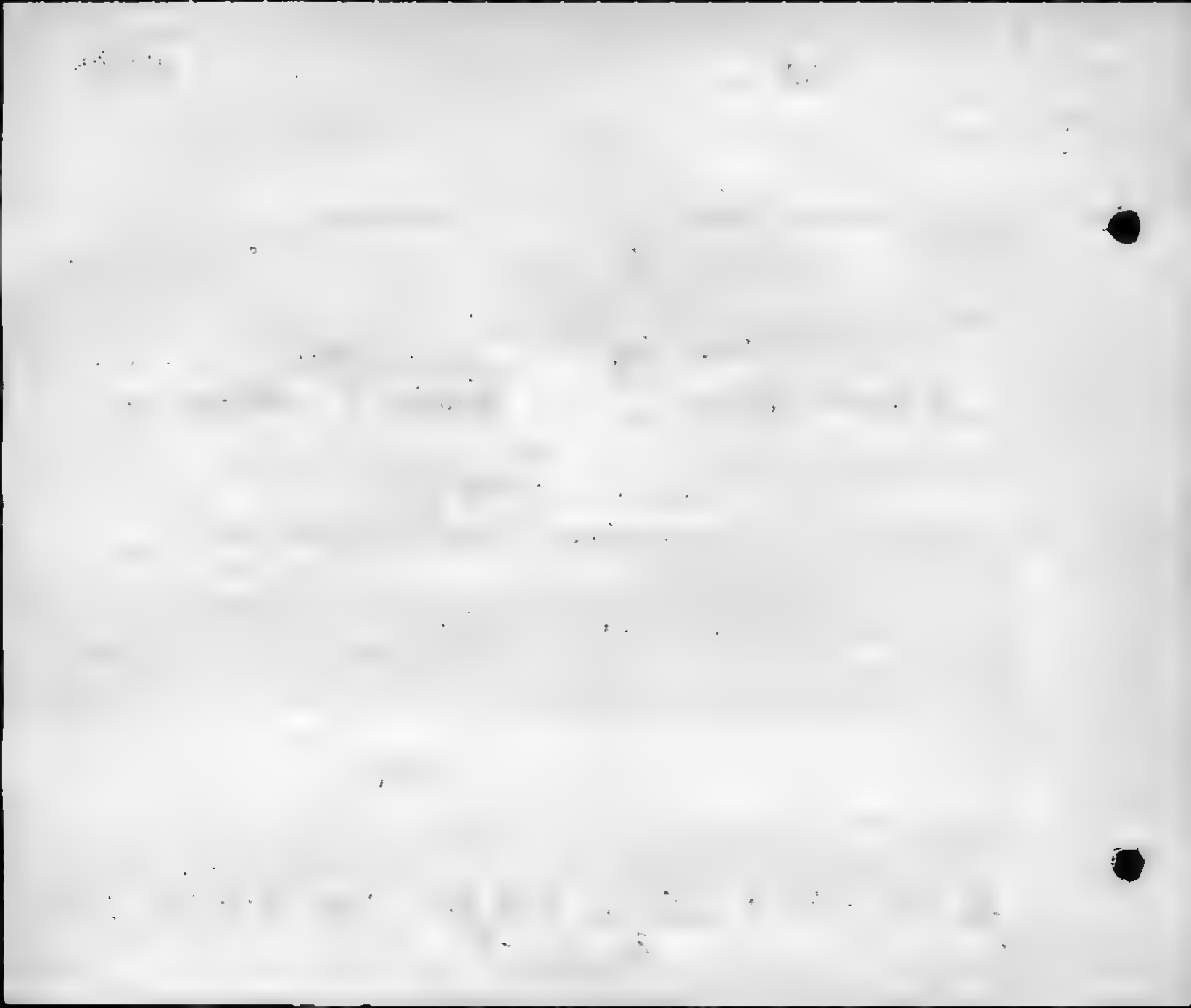
CERTIFICATE OF DEATH

2703

02683

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> <u>29 days</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>338 South Stricker Street</u>							
3. NAME OF DECEASED (Type or print) <u>Wallace P Bruce</u>				4. DATE OF DEATH Last <u>3</u> / Month <u>10</u> / Year <u>1961</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 30, 1896</u>					
9. AGE (In years last birthday) <u>65</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>For self</u>		11. BIRTHPLACE (Country & State, or foreign country) <u>Maryland, Balto.</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months Days	Hours Min.										
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>John M. Bruce</u>							
14. MOTHER'S MAIDEN NAME <u>Louise C. Schramm</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>							
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> (b) <u>Artherosclerotic Cardiovascular Disease</u> (c) <u>Jaundice of unknown etiology</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 8, 1961</u> to <u>March 10, 1961</u> that (I) (we) last saw the deceased alive on <u>March 10, 1961</u> and that death occurred at <u>7:12 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Bruno Radauskas</u>				22b. DATE SIGNED <u>3/10/1961</u>							
22c. PHYSICIAN'S NAME (Type) <u>BRUNO RADAUSKAS</u>				22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/14/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cem.</u>		23d. LOCATION (City, town or county) (State) <u>3801 Frederick Ave</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 13 '61</u>							
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>											

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2704

02684

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY 5	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	c. LENGTH OF STAY IN lb Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4601 Kenwood Ave.		d. STREET ADDRESS 4601 Kenwood Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Margaret Middle Brueckner Last Brueckner		4. DATE OF DEATH Month 3 Day 2 Year 1961	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-1893
9. AGE (In years lost birthday) 71 yrs		IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min 1	IF UNDER 24 HRS Hours 1 Min 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Zabel	
14. MOTHER'S MAIDEN NAME Margaret Schwartz		15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Casper J. Brueckner Address 4713 Ridgeway Ave. 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH many yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-1 1960 to 3-2 1961, that (I) (we) last saw the deceased alive on 2-13 1961, and that death occurred at 10PM , from the causes and on the date stated above			
22a. SIGNATURE Max R. English M.D.		22b. DATE SIGNED 3-3-61	
22c. PHYSICIAN'S NAME (Type) Max R. English M.D.		22d. ADDRESS 5713 Belair Rd. Balto. 6.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-6-1961	23c. NAME OF CEMETERY OR CREMATORY Parkwood	23d. LOCATION (City, town, or county) (State) Baltimore Md.
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Rd.		25a. REC'D BY REGISTRAR DATE MAR 6 '61	25b. REGISTRAR'S SIGNATURE Arthur L. Hines

TO HOS
may be
TO FUNE
page 3

VS A15 (4)
15M 9/55

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within
by the hospital or attending physician.
DIRECTOR: After this certificate has been signed by the attending physician and completely filled
out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. "

"s after death: Page 4
by the funeral director,
2 should be filled with

2705

CERTIFICATE OF DEATH

Reg. Dist. No. 02685

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Randallstown		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chapel Hill Convalescent Home		d. STREET ADDRESS 203 Kemble Road	
3. NAME OF DECEASED (Type or print) FRANCES BUCKLEY		4. DATE OF DEATH Month March Day 29 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1883
9. AGE (In years lost birthday) 77 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Richard M. Forbes		Address 1432 Park Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 337 X IMMEDIATE CAUSE (a) Cerebral Hemorrhage (Recurrent) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 21 Hypertensive Heart Disease DUE TO (c) 3			INTERVAL BETWEEN ONSET AND DEATH 2 hours 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from FEB. 7, 1960 to March 29, 1961 , that I last saw the deceased alive on March 19, 1961 , and that death occurred at 4 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7108 Liberty Heights Ave.			
ACTUAL SIGNATURE Earl L. Chambers		M.D. Baltimore - 7 Maryland	
PHYSICIAN'S NAME (Type) EARL - L - CHAMBERS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 1, 1961	22c. NAME OF CEMETERY OR CREMATORY Louder Park	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.		24a. REC'D BY REGISTRAR APR 4 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

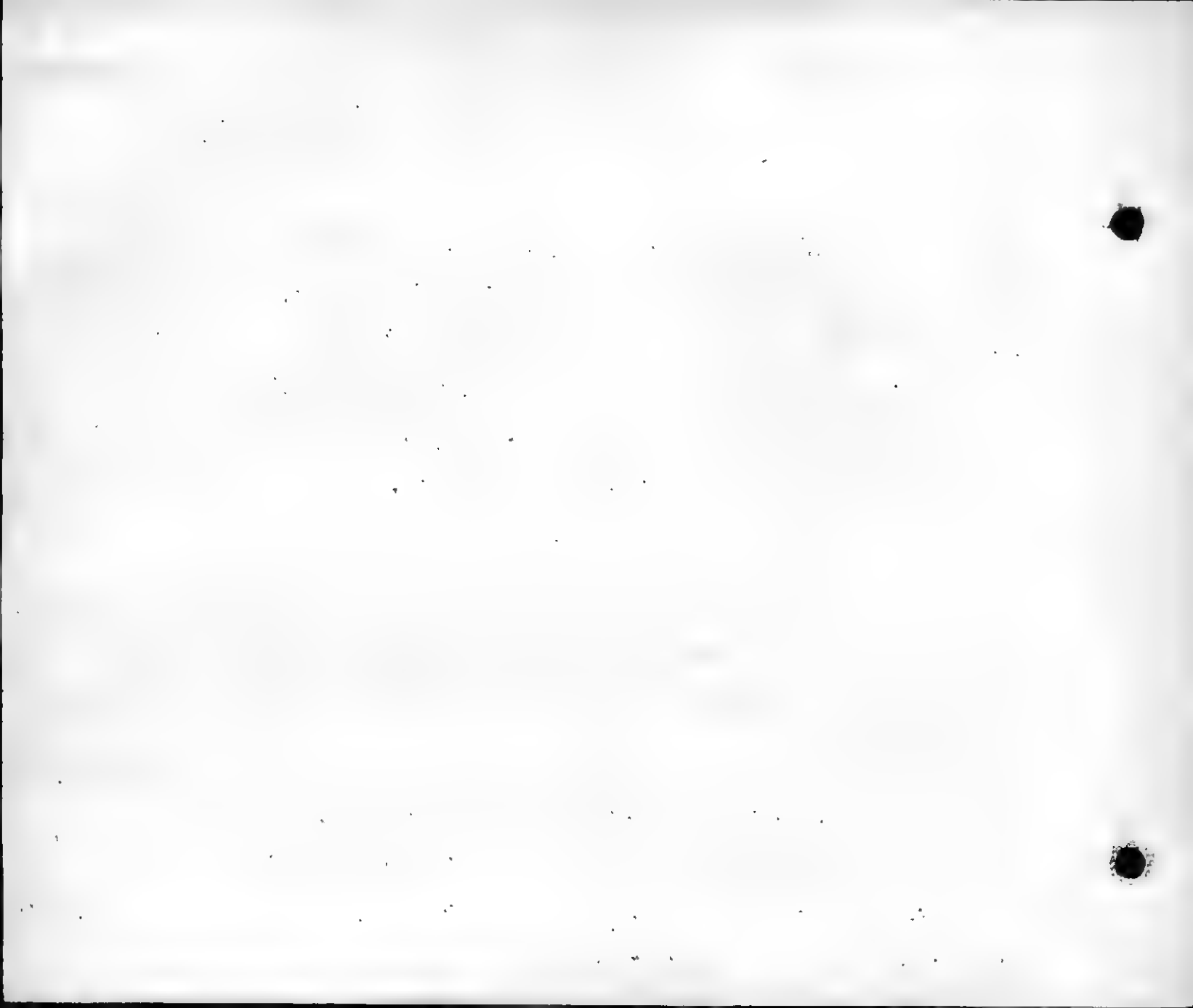
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

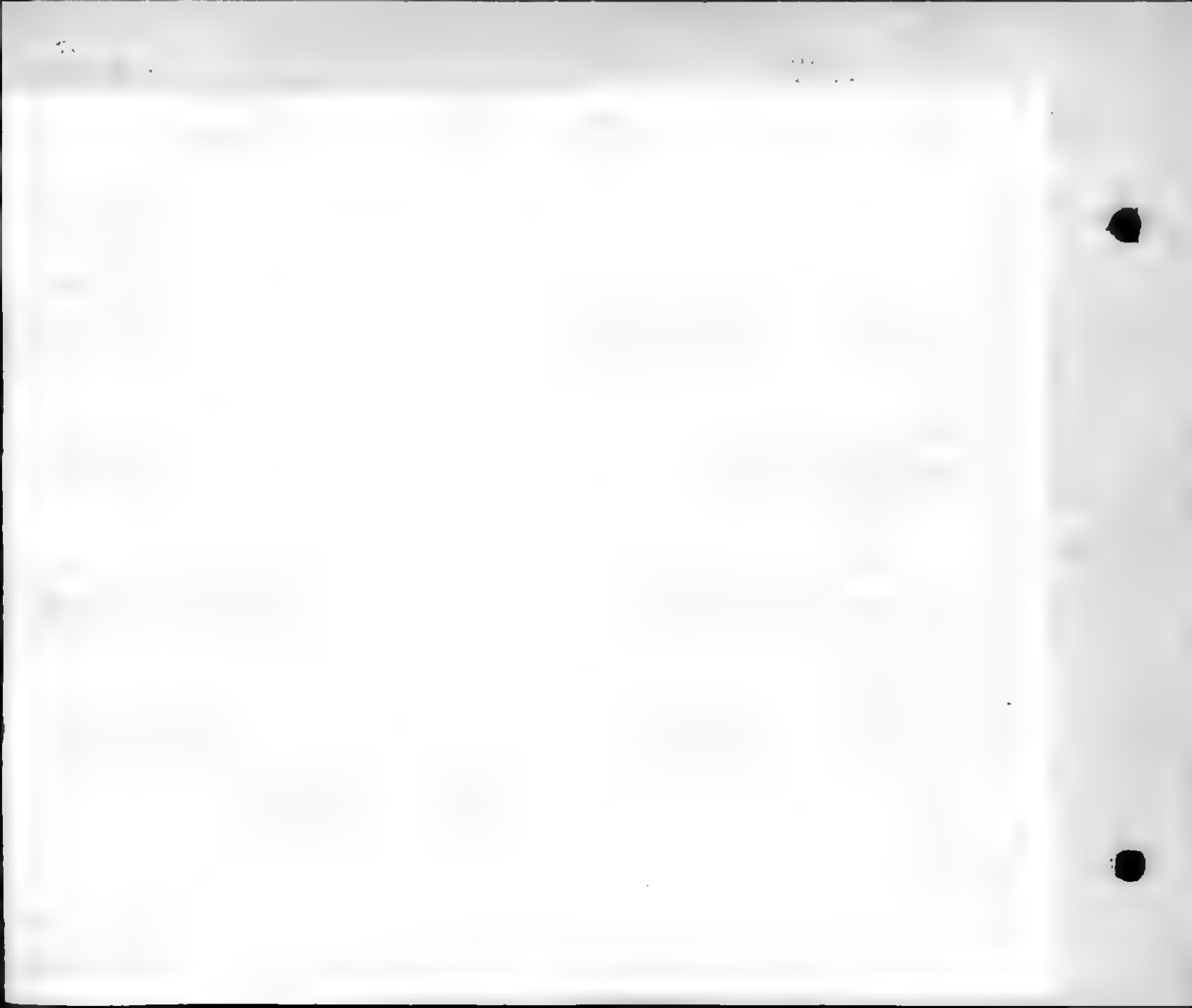
CERTIFICATE OF DEATH

Reg. Dist. No. 02686

2706

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. LENGTH OF STAY IN 1b <u>2 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris</u>				e. STREET ADDRESS <u>DULANEY VALLEY RD</u>			
3. NAME OF DECEASED (Type or print) <u>William P. Burlage</u>				4. DATE OF DEATH <u>3 1 1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/8/84</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balt. City</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Burlage</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Kohlman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-05-8906</u>			
				INFORMANT <u>SISTER - M CELESTE - STELLA MARIS HOSPICE</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ABCD</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9/17</u> , 19 <u>60</u> , to <u>3/1</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2/25</u> , 19 <u>61</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert J. Mahon</u> M.D.				ADDRESS (Street, city or town, state) <u>602 E Joppa Rd. Towson & MD.</u>			
PHYSICIAN'S NAME (Type) <u>R. J. MAHON</u> M.D.				DATE SIGNED <u>3/1/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-4-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE - MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W M COOK - TOWSON, INC - TOWSON - MD</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. H...</u>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

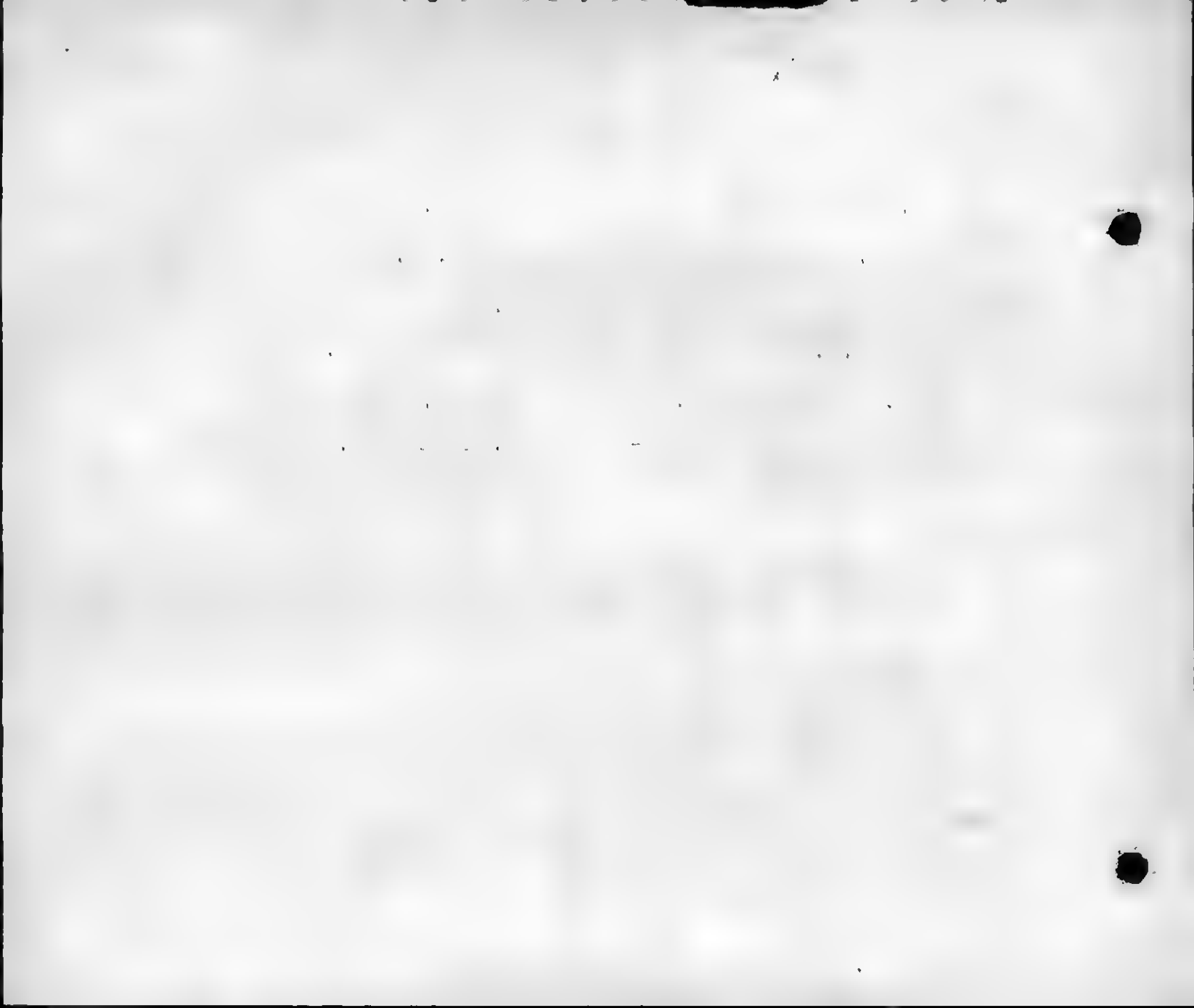
Reg. Dist. No. **02688**

2708

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Timonium</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>315 c. Timonium Road</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mr. John George Chenoweth, Jr.</i>				4. DATE OF DEATH Month Day Year <i>March 18th 19 61</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 26, 1909</i>	9. AGE (In years last birthday) <i>52</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Broker N.Y. Stock Exchange</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Exchange</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Co. Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John G. Chenoweth, Sr.</i>				14. MOTHER'S MAIDEN NAME <i>Mary E. Fuller</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>215-03-5510</i>		17. INFORMANT Address <i>Mrs. Lillian H. Chenoweth same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>4:10:1</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Sudden</i> (c), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Charles O'Donnell</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <i>3/20/61</i>		
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/22/61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Wiseburg Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>White Hall, Maryland</i>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Leonard J. Ruck 5305 Harford Road #14</i>			24a. REC'D BY REGISTRAR DATE <i>MAR 21 '61</i>	24b. REGISTRAR'S SIGNATURE <i>C. S. S. Kline</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2709

02689

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Parkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Millers Lane				d. STREET ADDRESS 1 Millers Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Lawrence Elijah Chilcoat				4. DATE OF DEATH Month Day Year 3 8 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-23-1891		9. AGE (In years last birthday) 69 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Chilcoat				14. MOTHER'S MAIDEN NAME Laura Guyton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-36-0022		17. INFORMANT Address Mrs. May Chilcoat Millers Lane Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arterio-sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH instant
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 1960 to Mar. 9, 1961 , that (I) (we) last saw the deceased alive on Mar. 7, 1961 , and that death occurred at 7 P.M. from the causes and on the date stated above.							
22a. SIGNATURE A. M. France				22b. DATE SIGNED 3/9/61			
22c. PHYSICIAN'S NAME (Type) A. M. FRANCE				22d. ADDRESS Parkton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3-12-61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Hereford Assembly of God Parkton,		23d. LOCATION (City, town, or county) (State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service Towson 4, Md.				25a. REC'D BY REGISTRAR DATE MAR 13 '61		25b. REGISTRAR'S SIGNATURE Charles J. France	



2710

CERTIFICATE OF DEATH

Reg. Dist. No. 02630

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crawings Mills P.O.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crawings Mills - P.O.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at his home</u>		d. STREET ADDRESS <u>Garrison Forest & Caves Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Edward Cockey</u>		4. DATE OF DEATH <u>March 19 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/11/1908</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cable Jetties - Tomen - Myp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles E. Cockey</u>		14. MOTHER'S MAIDEN NAME <u>Annanda Crofner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes WWII</u>		16. SOCIAL SECURITY NO. <u>159-10-2988</u>	
17. INFORMANT <u>Mrs Louise Ames</u>		Address <u>10000 Garrison Forest Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PROSTATIC CARCINOMATOSIS</u> DUE TO (b) <u>11/11</u> DUE TO (c) <u>lying cause lost.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>NOVEMBER 1960</u> to <u>MARCH 1961</u> , that I last saw the deceased alive on <u>MARCH 18 1961</u> , and that death occurred at <u>1:00 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Carlton L. Sexton</u> M.D.		ADDRESS (Street, city or town, state) <u>819 PARK AVE. BALTIMORE, MD.</u>	
DATE SIGNED <u>MARCH 19, 1961</u>			
PHYSICIAN'S NAME (Type) <u>CARLTON L. SEXTON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 21/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenview</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Shaw & Moore</u>		ADDRESS <u>108 W York Balto</u>	
24a. REC'D BY REGISTRAR <u>Carl L. Sexton</u>		24b. REGISTRAR'S SIGNATURE <u>Carl L. Sexton</u>	
DATE <u>MAR 20 '61</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

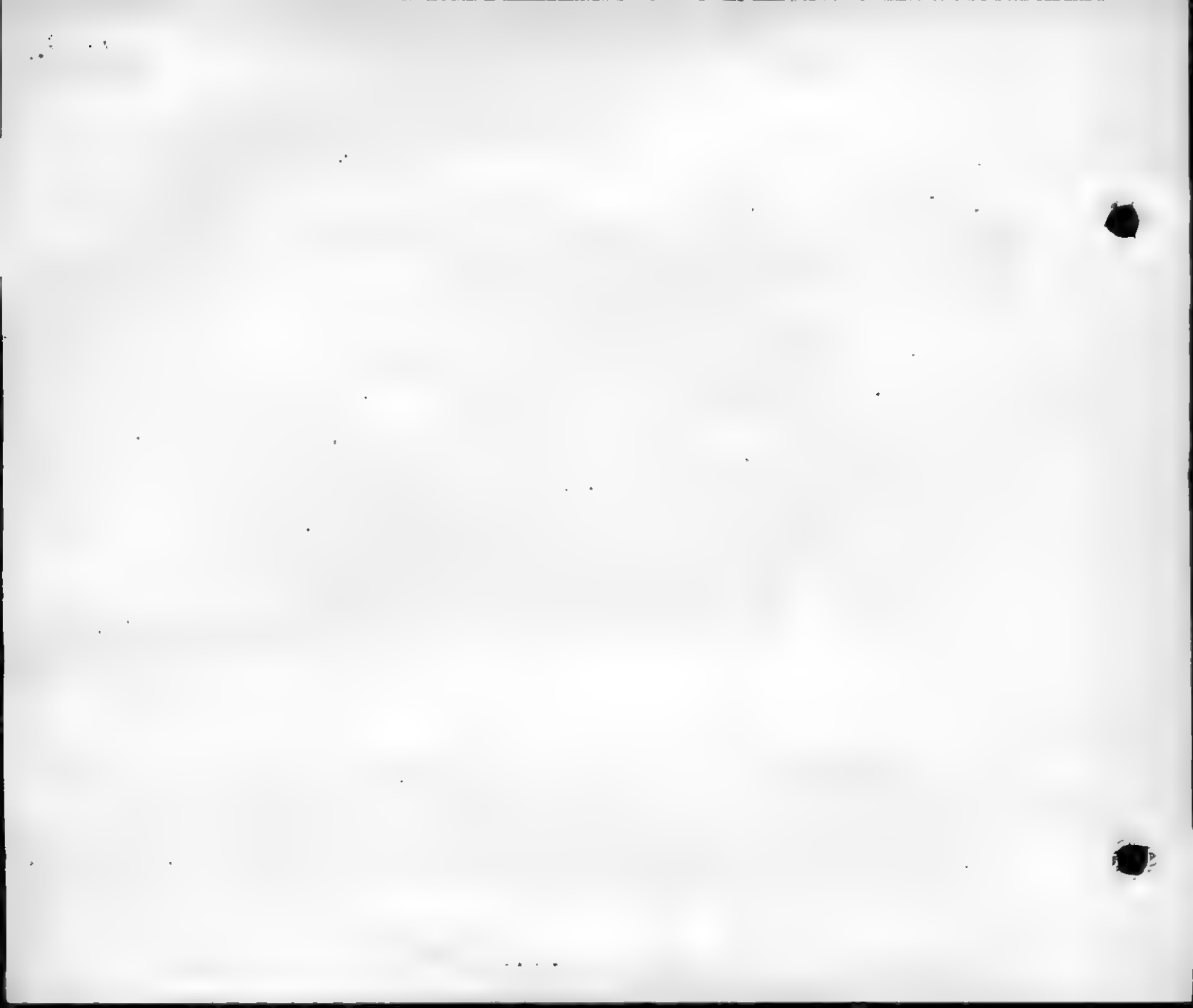
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2711

CERTIFICATE OF DEATH

02691

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whiteford		12-1-61	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS Whiteford, Maryland		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES R. COMBS		First Middle Last		4. DATE OF DEATH 3 7 19 61		Month Day Year	
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9. 2. 1894	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE HARVEY				14. MOTHER'S MAIDEN NAME EDITH SCARBER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. —		17. INFORMANT Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far advanced bilateral cavity pulmonary tuberculosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 2X DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tuberculous pericarditis. Emphysema, compensated.</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 3-2-1961 to 3-7-1961, that (I) (we) last saw the deceased alive on 3-7-1961, and that death occurred at 12:25 p.m. from the causes and on the date stated above 22a. SIGNATURE Wm. Newcomer 22b. DATE SIGNED 3-7-1961 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent 22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md. 23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Burial 23b. DATE THEREOF 3-10-61 23c. NAME OF CEMETERY OR CREMATORY FELLOWSHIP 23d. LOCATION (City, town, or county) (State) RYLESVILLE, MD. 24. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins 25a. REC'D BY REGISTRAR MAR 10 '61 25b. REGISTRAR'S SIGNATURE C. L. H. Harkins							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

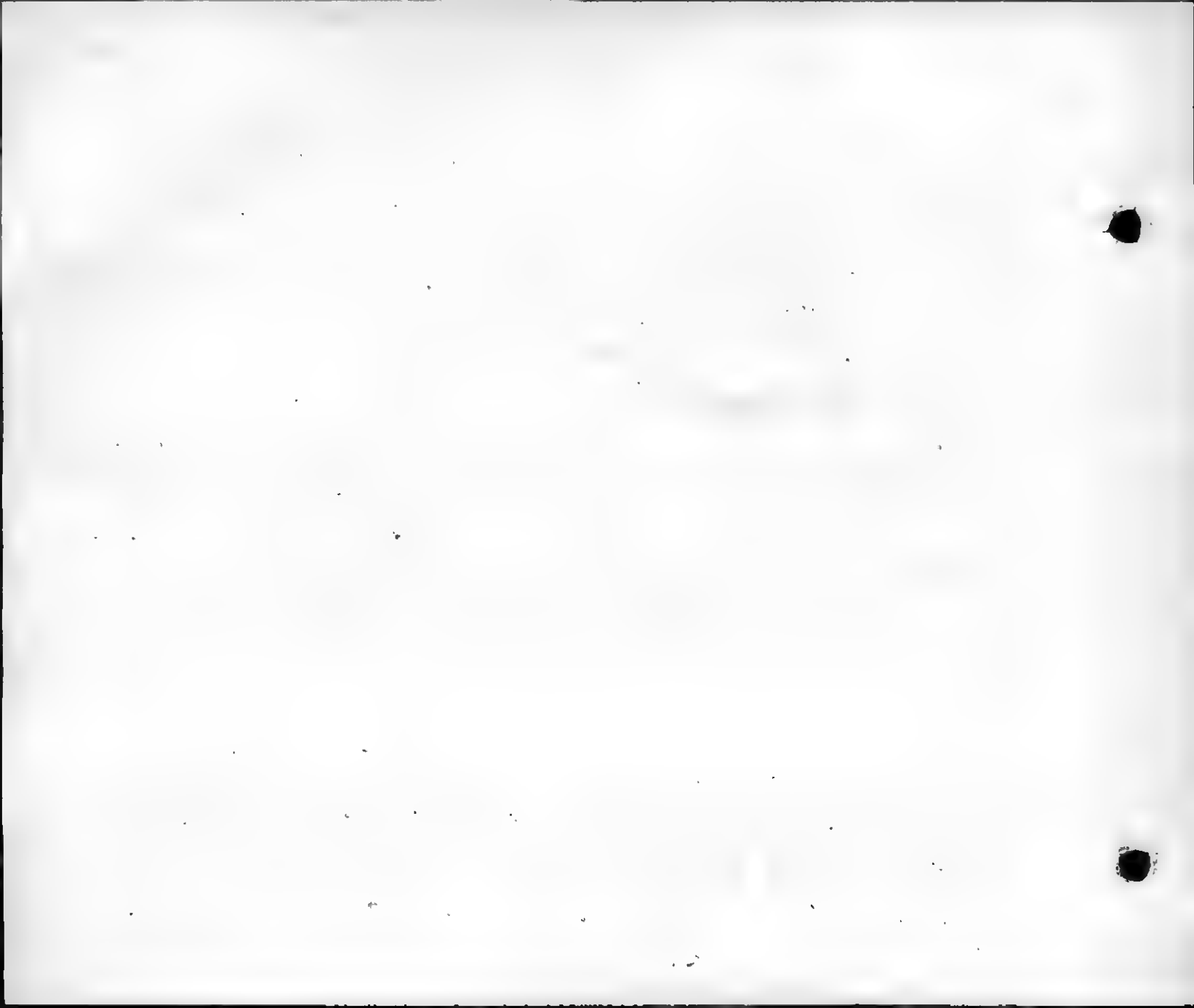
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Filed 3-14-61 et

CERTIFICATE OF DEATH

Reg. Dist. No. 02692

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eastonville</u> c. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Blackwell Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eastonville</u> d. STREET ADDRESS <u>1231 Maple Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Cornelly</u> Last <u>Cornelly</u>		4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 6 - 1883</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9c. AGE (In years last birthday) <u>77</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	10c. AGE (In years last birthday) <u>77</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Fredrick Weisenborn</u>		14. MOTHER'S MAIDEN NAME <u>(Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(Yes, no, or unknown)</u>		16. SOCIAL SECURITY NO. <u>(Yes, no, or unknown)</u>	
17. INFORMANT <u>Mr. James E. Cornelly</u>		Address <u>1231 Maple Ave (27)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 31X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular atherosclerosis</u> DUE TO (c) <u>5 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 28, 1960</u> to <u>March 6, 1961</u> that I last saw the deceased alive on <u>Feb 28, 1961</u> and that death occurred at <u>5:40 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Nelson McKay</u>		ADDRESS (Street, city or town, state) <u>6014 Edmondson Ave Balt 2024</u> DATE SIGNED <u>3/6/61</u>	
PHYSICIAN'S NAME (Type) <u>J. NELSON MCKAY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/9/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park, Md.</u>		22d. LOCATION (City, town or county) (State) <u>3801 Frederick Ave</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Bowman Fox</u>		ADDRESS <u>901-3 Hollins St</u>	
24a. REC'D BY REGISTRAR <u>MAR 8 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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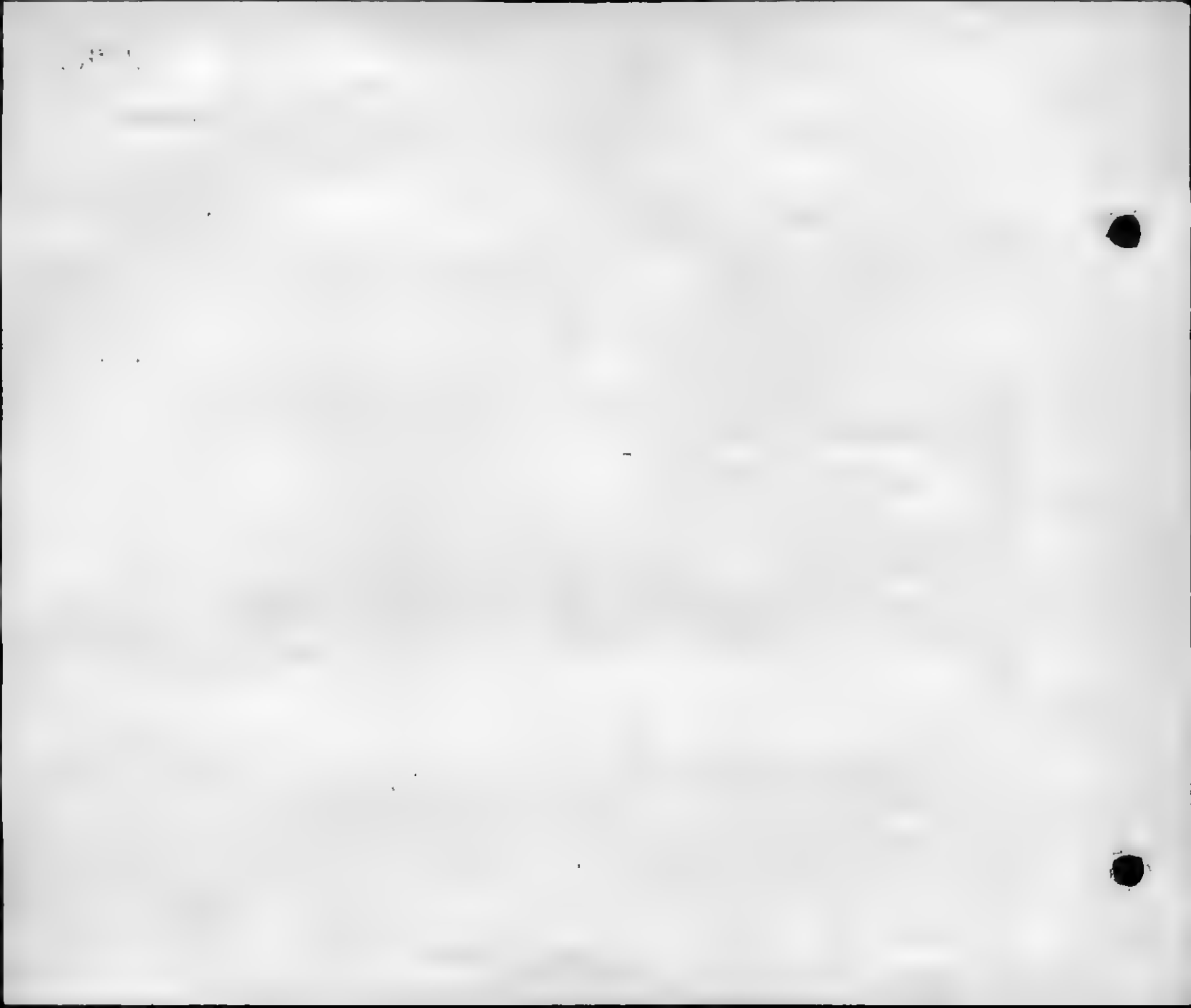
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2713

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02693

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>22</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN TB <u>3yr5mt15dys</u>				d. STREET ADDRESS <u>Eutaw place and Lavale St.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Georgina Florian Conner</u>				4. DATE OF DEATH Month Day Year <u>March 19 1961</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 6, 1889</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waitress</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
10a. KIND OF BUSINESS OR INDUSTRY				13. FATHER'S NAME <u>Charles Florian</u>			
14. MOTHER'S MAIDEN NAME <u>Georgia Sterling</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>unknown</u>			
16. SOCIAL SECURITY NO. <u>40-26-4327</u>				17. INFORMANT <u>Records; SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 7-0-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>obesity</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 4, 1957</u> to <u>March 19, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 19, 1961</u> , and that death occurred at <u>1:20 p.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Stella Wachslar, M. D.</u>				22b. DATE SIGNED <u>3- -61</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</u>			
23a. BURIAL, CREMATION, OR OTHER (Specify)		23b. DATE THEREOF <u>3/31/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calverton</u>		23d. LOCATION (City, town or county) (State) <u>Calverton, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Talley</u>				25. REC'D BY REGISTRAR <u>APR 3 61</u>			
25a. ADDRESS <u>1318 Light</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

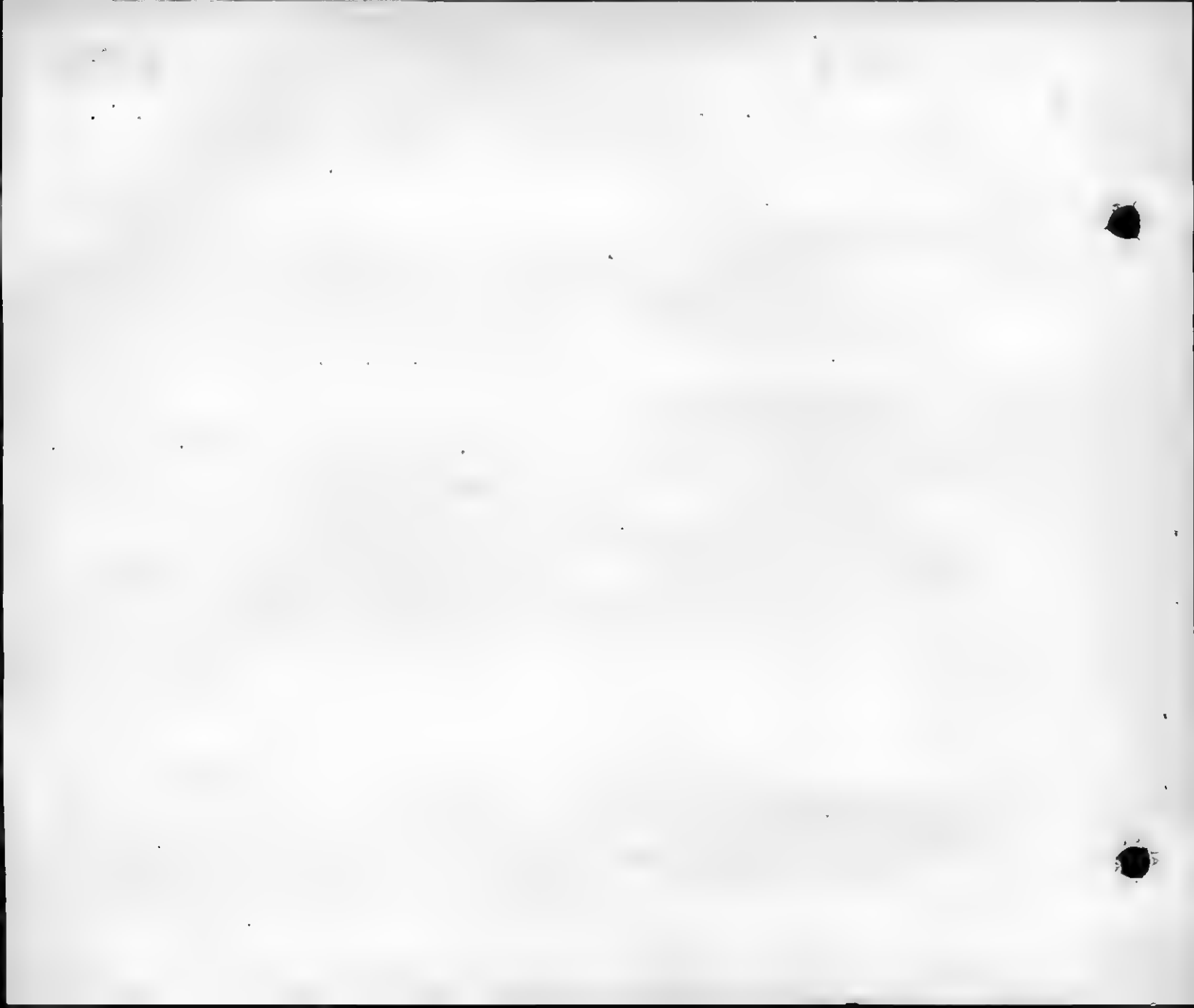
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2714

CERTIFICATE OF DEATH

02694

1. PLACE OF DEATH a. COUNTY Balto. Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Balto. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ebenezer Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase Md.	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret P. Crouch		4. DATE OF DEATH Month Day Year 3 8 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-5-1869
9. AGE (In years last birthday) 91 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joshua Crouch League		14. MOTHER'S MAIDEN NAME Annie Rollins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT John W. Crouch		Address 27 Cedar Ave. Towson 's.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 1270 DUE TO ARTERIO-SCLEROTIC HEART Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO DISEASE WITH HYPERTENSION (c)			INTERVAL BETWEEN ONSET AND DEATH 4 WEEKS 8 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from SEPT 1959 to MAR 8 1961, that (I) (we) last saw the deceased alive on MAR 8 1961, and that death occurred at 6 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Joseph Miceli M.D.		22b. DATE SIGNED 3/10/61	
22c. PHYSICIAN'S NAME (Type) JOSEPH MICELI, M.D.		22d. ADDRESS 108 S. TAYLOR AVE BALTO. 21, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-11-1961	
23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		23d. LOCATION (City, town, or county) (State) Balto. Co. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Rd #6.		25a. REC'D BY REGISTRAR DATE MAR 13 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

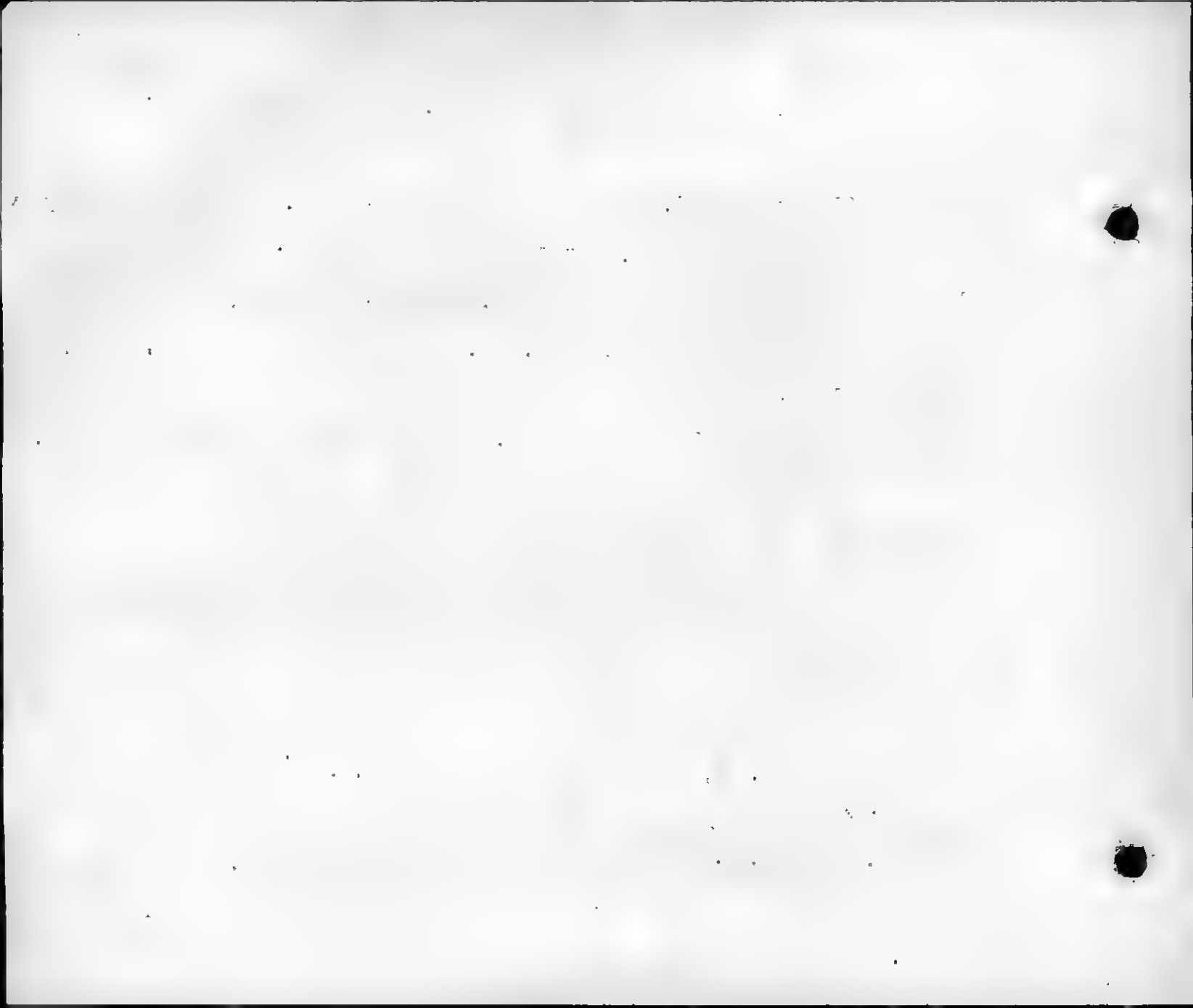
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2715

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02695

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b Baltimore d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1521 Barrett Rd. #7		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baltimore d. STREET ADDRESS 1521 Barrett Rd. #7 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anthony Middle J. Last Culotta		4. DATE OF DEATH Month March Day 2 Year 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1899 9. AGE (In years last birthday) 62yr 8m.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) guard		10b. KIND OF BUSINESS OR INDUSTRY Pinkerton Dect. Agy. Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Philip Gugliotta		14. MOTHER'S MAIDEN NAME Josephine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 215 32 8185	
17. INFORMANT (daughter) Mrs. Josephine Bumba		Address 924 Elmridge Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Coronary artery occlusion Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 21, 19 54 to March 27, 19 61 that (I) (we) last saw the deceased alive on Feb. 27, 19 61 , and that death occurred at 9:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE OF PHYSICIAN Harry L. Knipp, M. D.		22b. DATE SIGNED 3/2/61	
22c. PHYSICIAN'S NAME (Type) Harry L. Knipp, M. D.		22d. ADDRESS 4116 Edmondson Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/6/61	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery Baltimore, Maryland		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR DATE MAR 6 '61	
ADDRESS 4107 Wilkens Avenue		25b. REGISTRAR'S SIGNATURE C. W. S. Lewis	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



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MEDICAL CERTIFICATION

<p align="center">MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH Item 9 Film 0283 3/30/61 ph</p>																																	
1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville		c. LENGTH OF STAY IN 1b 22yr10mth10dys		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland		b. COUNTY Baltimore																									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville, Maryland				d. STREET ADDRESS Seminary Avenue																									
3. NAME OF DECEASED (Type or print) (Betty) ELIZABETH A.		First		Middle		Last		4. DATE OF DEATH Month March Day 21 Year 19 61																									
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 26, 1920		9. AGE (In year, last birthday) 40 yrs.																									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.																											
13. FATHER'S NAME George Dedal				14. MOTHER'S MAIDEN NAME Florence Scott																													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address																									
18. CAUSE OF DEATH (Enter only one cause per line for [a], [b], and [c].)																																	
<table border="0"> <tr> <td colspan="2">PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</td> <td colspan="2">Congestive heart failure</td> <td colspan="2">INTERVAL BETWEEN ONSET AND DEATH</td> </tr> <tr> <td colspan="2">DUE TO</td> <td colspan="2"></td> <td colspan="2"></td> </tr> <tr> <td colspan="2">Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.</td> <td colspan="2">(b) Status convulsivus</td> <td colspan="2"></td> </tr> <tr> <td colspan="2"></td> <td colspan="2">(c) Idiopathic epilepsy</td> <td colspan="2"></td> </tr> </table>										PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH		DUE TO						Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		(b) Status convulsivus						(c) Idiopathic epilepsy			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH																													
DUE TO																																	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		(b) Status convulsivus																															
		(c) Idiopathic epilepsy																															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).																																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18.)																													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)																									
21. I certify that (I) (this hospital) attended the deceased from July 1, 1956 to March 21, 1961 , that (I) (we) last saw the deceased alive on March 21, 1961 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.																																	
22a. SIGNATURE Stella Wachslar, M. D.				22b. DATE SIGNED 3-21-61		22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.																											
22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonville 28, Md.																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 24, 1961		23c. NAME OF CEMETERY OR CREMATORY Sater's Baptist Cemetery		23d. LOCATION (City, town or county) Lutherville, Maryland																											
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines																											

02696

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2717 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02697

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex #21</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex #21</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>405 Worton Road</u>		d. STREET ADDRESS <u>405 Worton Road</u>	
3. NAME OF DECEASED (Type or print) <u>DANIEL JOSEPH DELEA SR.</u>		4. DATE OF DEATH <u>March 11, 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30, 1892</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>traffic eng.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Delea</u>		14. MOTHER'S MAIDEN NAME <u>Ann McHale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO <u>212-03-1711</u>	
17. INFORMANT <u>Delores warnecker</u>		Address <u>221 A Sava ...</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A-S-C-V Disease</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>		20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		20g. (County) <u> </u>	
20h. (State) <u> </u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. Davis, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3/11/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/14/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James ...</u>		24a. REC'D BY REGISTRAR <u> </u>	
ADDRESS <u>1107 Eastern Ave.</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>APR 14 '61</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2718

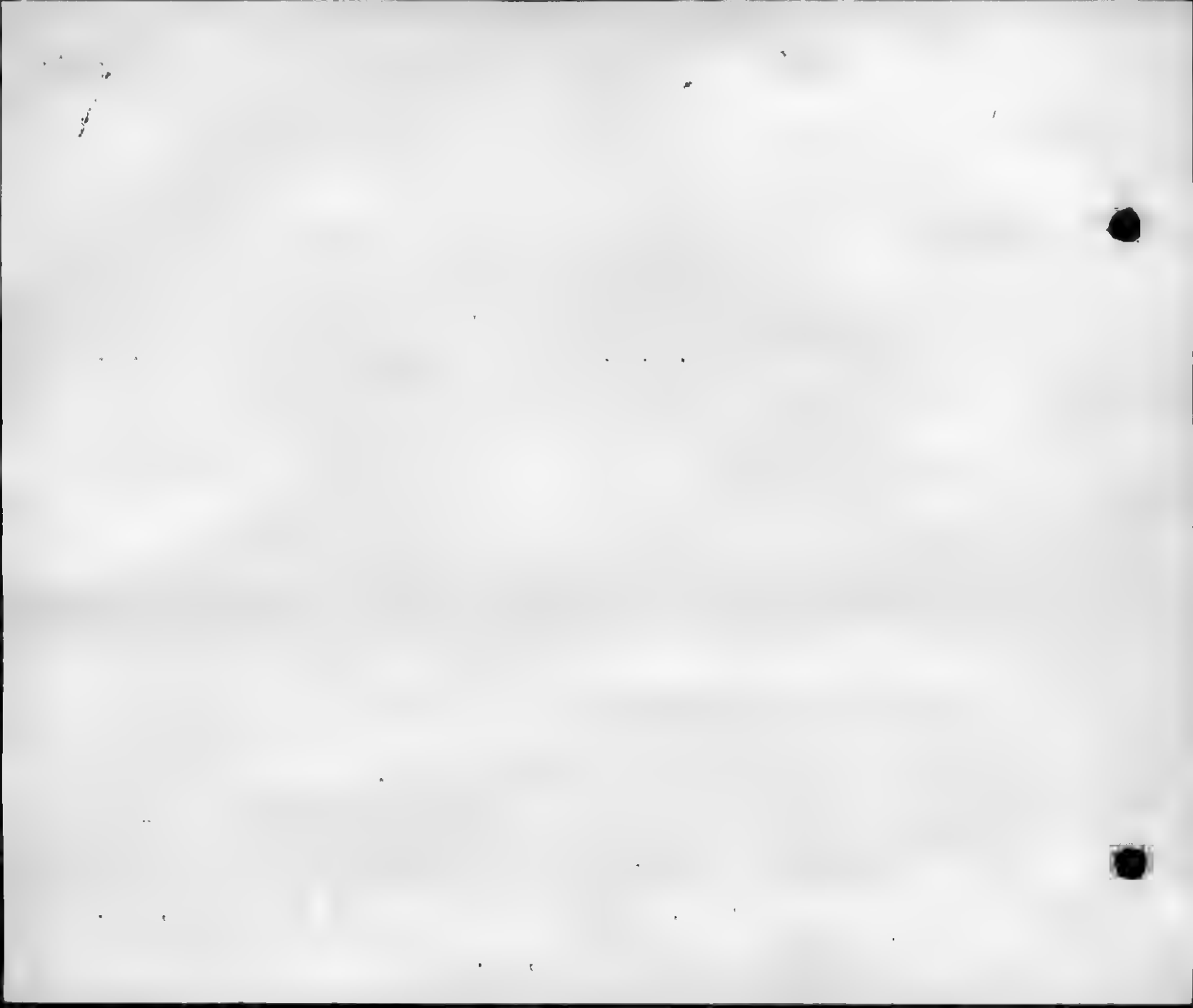
CERTIFICATE OF DEATH

02698

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>16 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton, Maryland</u> d. STREET ADDRESS <u>Box 184</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lester Lee Disney</u>		4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>19 61</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 11, 1871</u>		9. AGE (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maintenance man (ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>P. R. R.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Andrew J. Disney</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Redmiles</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> (b) <u>Arteriosclerosis, generalized and severe</u> (c) <u>Arteriosclerosis, generalized and severe</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Nephrosclerosis</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 14, 1961</u> to <u>March 16, 1961</u>, that (I) (we) last saw the deceased alive on <u>March 16, 1961</u>, and that death occurred at <u>2:30</u> a.m., from the causes and on the date stated above.			
22a. SIGNATURE <u>Stella Wachsler, M. D.</u>		22b. DATE SIGNED <u>3-16-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>18th March '61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Anne Arundel Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		25a. REC'D BY REGISTRAR <u>MAR 20 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. ADDRESS <u>Glen Burnie, Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed in by the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2719
CERTIFICATE OF DEATH
02699

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY N 1b <u>X</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>122 Melvin Ave.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>122 Melvin Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>THOMAS J. EARLE</u>		4. DATE OF DEATH <u>March 16 1961</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/21/91</u>		9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roughmont Mach. Co. Ret.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert H. Earle</u>				14. MOTHER'S MAIDEN NAME <u>Annie Flynn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year and dates of service) <u>Yes WWI</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Mrs. Newman E. Earle</u>				Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>101</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Hypertensive Heart Vascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yr.</u> <u>10 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u>61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>3:07 P.M., 1961</u> to <u>3:16 P.M., 1961</u> , that (I) (we) last saw the deceased alive on <u>3-3-1961</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William K. Gailage</u>				22b. DATE SIGNED <u>3-17-61</u>		22c. PHYSICIAN'S NAME (Type) <u>William K. Gailage MD</u>	
22d. ADDRESS <u>6209 2nd St. Catonsville, Md.</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/20/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Staff</u>				24b. ADDRESS <u>28</u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u> </u>				DATE <u>MAR 20 1961</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2720

2720

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02700

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 102 E. SUSQUEHANNA AVE.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON d. STREET ADDRESS 102 E. SUSQUEHANNA AVE.			
3. NAME OF DECEASED (Type or print) JOHN PAUL EATON				4. DATE OF DEATH MARCH 13 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 20, 1904	
9. AGE (in years last birthday) 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMMUEL EATON				14. MOTHER'S MAIDEN NAME CATHERIN HOFMEISTER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. A 217-03-2588			
17. INFORMATION FAMILY RECORDS				Address			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arteriosclerotic Cardio-Renal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) Vascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Sudden 3 yrs				INTERVAL BETWEEN ONSET AND DEATH 3 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1948 to March 13, 1961 , that (I) (we) last saw the deceased alive on March 10, 1961 , and that death occurred at 9:45 M, from the causes and on the date stated above.							
22a. SIGNATURE Charles H. Hounsell M.D.				22b. DATE SIGNED MARCH 13 1961			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/16/61		23c. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL PARK		23d. LOCATION (City, town or county) (State) PARKVILLE MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns, Towson, Maryland				25a. REC'D BY REGISTRAR MAR 20 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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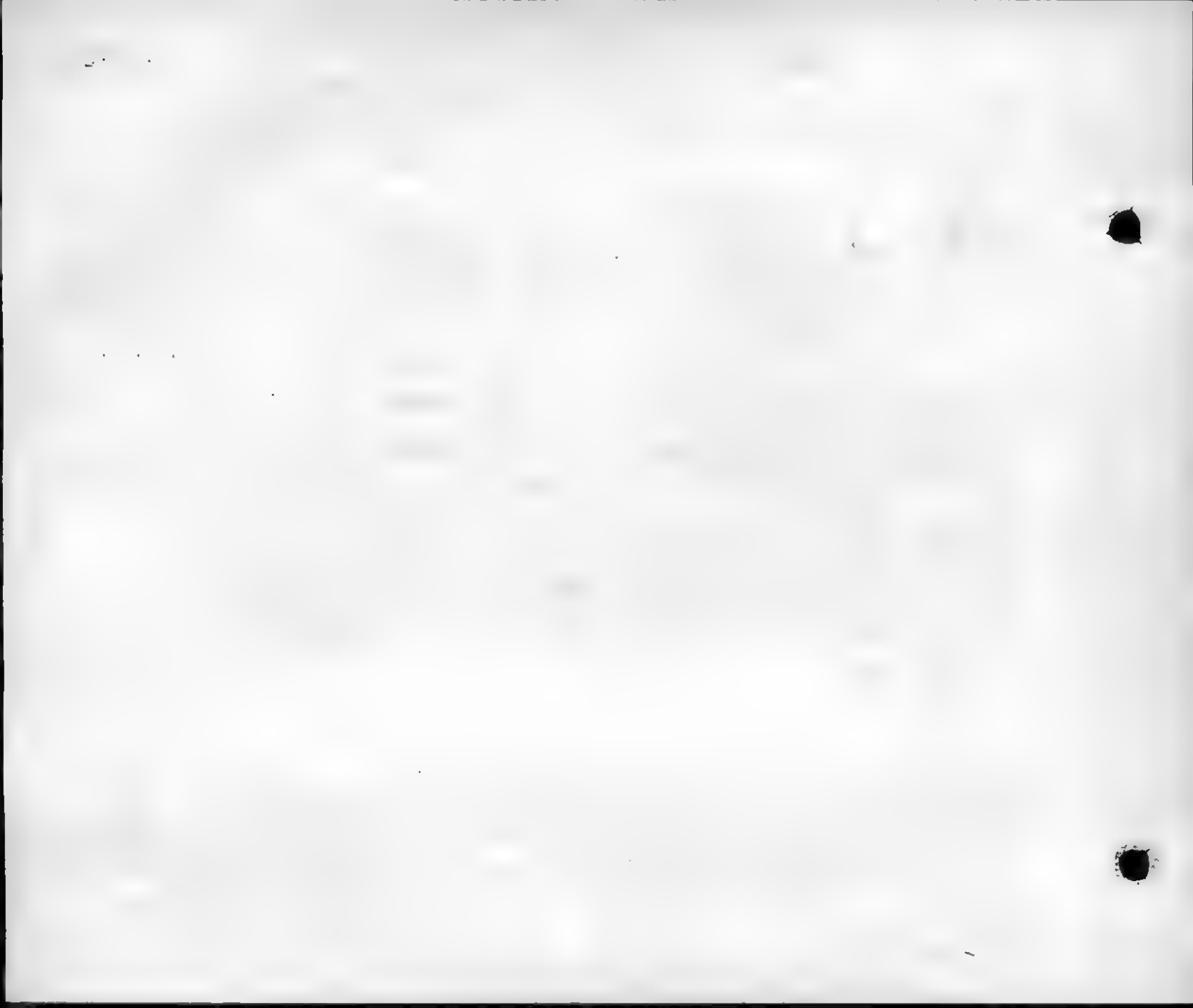
may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2721

STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02701

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 27 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) W.M. Raymond First W. Middle H. Last Ehlers				4. DATE OF DEATH Month March Day 29 Year 19 61			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 15, 1881	
9. AGE (In years last birthday) 79 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanical eng.				10b. KIND OF BUSINESS OR INDUSTRY RET.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME unknown LEWIS EHLERS				14. MOTHER'S MAIDEN NAME unknown ISSAC			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) Cardiac failure DUE TO (c) Arteriosclerotic cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) March 14, 19 61				20g. (County) March 29, 19 61			
21. I certify that (I) (this hospital) attended the deceased from March 14, 19 61 to March 29, 19 61 that (I) (we) last saw the deceased alive on March 29, 19 61 , and that death occurred at 3:00 P. from the causes and on the date stated above.							
22a. SIGNATURE Stella Wacholer, M. D.				22b. DATE SIGNED 3-29-61			
22c. PHYSICIAN'S NAME (Type) Stella Wacholer, M. D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/1/61		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN		23d. LOCATION (City, town, or county) (State) BALTO. CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Hoff, Son Co. 28				25a. REC'D BY REGISTRAR MAR 30 61		25b. REGISTRAR'S SIGNATURE Arthur S. Thayer	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2722

02702

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>424 Greenlow Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>424 Greenlow Road</u>			
3. NAME OF DECEASED (Type or print) <u>Catherine L. Essert</u>		4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Sept. 26, 1923</u>		9. AGE (In years last birthday) <u>37</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never Worked</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Frank L. Essert</u>		14. MOTHER'S MAIDEN NAME <u>Edna T. Hayden</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Edna T. Essert-424 Greenlow Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> Condition (b) <u>Adenocarcinoma of Intestine</u> (a), stating the underlying cause last. (c) <u> </u> PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>							
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from. <u>about</u> <u>1936</u> , to <u>3-25</u> , 19 <u>61</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>3-23</u> , 19 <u>61</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Gustav Highstein</u>		22b. DATE SIGNED <u>3-27-61</u>		22c. PHYSICIAN'S NAME (Type) <u>GUSTAV HIGHSTEIN</u>			
22d. ADDRESS <u>888 W Lombard St</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-29-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>			
23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u>		23e. ADDRESS <u> </u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 27 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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FOR STATE
HEALTH DEPT.
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TO THE CITY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2725

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02703

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 3510 Holmes Avenue	
3. NAME OF DECEASED (Type or print) Israel		4. DATE OF DEATH Month March Day 31 Year 1961	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1879	
9. AGE (in years, if UNDER 1 YEAR, last birthday) 81 yrs.		10. AGE (in years, if UNDER 1 YEAR, last birthday) 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) rag picker		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia	
13. FATHER'S NAME Erey Exler		14. MOTHER'S MAIDEN NAME Hilda Flaxman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7913-7 DUE TO acute congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cardiovascular disease (c) fracture right femur PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: On 1-29-61 an open reduction and internal fixation with Smith-Peterson nail and McLaughlin Side plate and screws was performed 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. EXTERNAL CAUSE OF DEATH (If any, state it) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) On 1-19-61 while on the way to the diningroom, patient was knocked down by another pt. sustaining an intertrochanteric frac. of the right femur 20c. TIME OF INJURY Month, Day, Year 5:00 p.m. 1-19-1961 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work hospital 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Catonsville 28, Md. 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE George M. Kieffer M.D. EXAMINER'S NAME (Type) George M. Kieffer, M.D. 22a. BURIAL, CREMATION, or REMOVAL (Specify) Removal 22b. DATE THEREOF 4-3-61 22c. NAME OF CEMETERY OR CREMATORY Rosedale 22d. LOCATION (City, town, or country) (State) Balto Md 23. FUNERAL DIRECTOR Jack Lewis Inc ADDRESS 2100 Eutan Pl 24a. REC'D BY REGISTRAR APR 4 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Hume			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

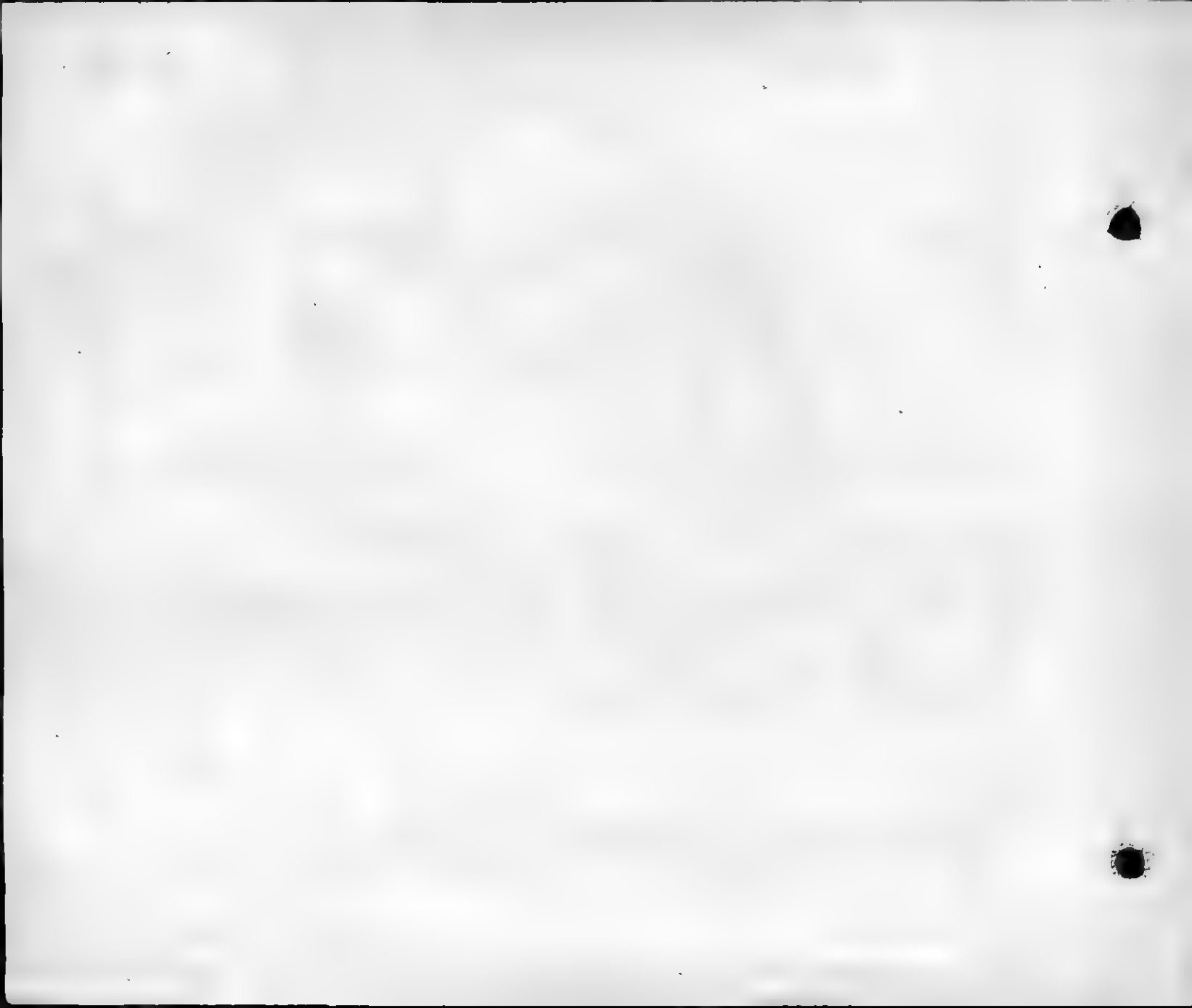
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2724

Reg. Dis. No. 02706

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STEMMERS RUN				c. LENGTH OF STAY IN 1b 9 MONTHS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1817 SUNNYSIDE RD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Michael Middle FANSLAU Last FANSLAU				4. DATE OF DEATH Month 3 Day 13 Year 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/11/1874	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY SHIPYARD		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? RUSSIA <input checked="" type="checkbox"/>							
13. FATHER'S NAME NOT KNOWN				14. MOTHER'S MAIDEN NAME NOT KNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 216-05-1421		17. INFORMANT Address MRS. EVA WEBB 1817 SUNNYSIDE RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation - Suicide DUE TO 779X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 10 min							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack E Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JACK E COLLINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/15/61		22c. NAME OF CEMETERY OR CREMATORY SCHWARTZ'S		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE B. W. Hoffmann				ADDRESS 3218 HUDSON ST. (24)		24a. REC'D BY REGISTRAR DATE MAR 14 '61	
				24b. REGISTRAR'S SIGNATURE Charles S. Fries			

THE DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your own use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registry prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2725

CERTIFICATE OF DEATH

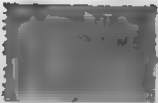
02705

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville 28</u> c. LENGTH OF STAY IN IL <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mrs. Bassett's Nursing Home</u> <u>335 Bloomsbury Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 26</u> d. STREET ADDRESS <u>7817 High Point Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bernard H. Farley</u>		4. DATE OF DEATH <u>March 2 19 61</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 3, 1894</u>	
9. AGE (in years last birthday) <u>66</u> yrs		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>2</u> IF UNDER 24 HRS: Hours <u>19</u> Min. <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home construction</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Princeton, W.Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henderson Farley</u>		14. MOTHER'S MAIDEN NAME <u>Nannie Hughes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war and dates of service)		16. SOCIAL SECURITY NO. <u>218-05-4215H</u>	
17. INFORMANT <u>Mrs. Nora Farley, White Marsh, Maryland</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction,</u> <u>42</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Cardio-Vascular System</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1.503</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that (I) (th's hospital) attended the deceased from <u>5-6-1961</u> to <u>3-2-1961</u> , that (I) (we) last saw the deceased alive on <u>3-4-1961</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Wilmer K. Gallagher</u>		22b. DATE SIGNED <u></u>	
22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher, M.D.</u>		22d. ADDRESS <u>6209 Frederick Rd. Catonsville 28, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-4-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) <u>3310 Taylor Avenue</u> (State) <u></u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		25a. REC'D BY REGISTRAR <u>MAR 6 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2726

CERTIFICATE OF DEATH

02706

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Harrisonville		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 231A Randallstown, P.O. Liberty Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle V. Last Fee		4. DATE OF DEATH Month March Day 5 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1879
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wienke		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Howard W. Fee		Address 4605 Wilkens Ave. Balto. 29, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Valvular Heart Disease DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/4/61 to 3/5/61 , 19 61 , that (I) (we) last saw the deceased alive on 3/5/61 , 19 61 , and that death occurred at 3:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Wm. E. Martin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wm. E. MARTIN		22d. ADDRESS Randallstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-9-1961	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Erving Byers		ADDRESS 8728 Liberty Road	
25a. REC'D BY REGISTRAR MAR 10 '61		25b. REGISTRAR'S SIGNATURE William S. Kraus	

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Randallstown, Md.



may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2727

02707

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6,			c. LENGTH OF STAY IN 1b 5 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4304 Necker Ave.				d. STREET ADDRESS 4304 Necker Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GUY ROLAND FISHPAW				4. DATE OF DEATH Month Day Year 3-2-61 19			
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH June 8, 1893		9. AGE (In years last birthday) 67 yrs	IF UNDER 1 YEAR Months Days Hours Mins 8 24 13 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cooper		10b. KIND OF BUSINESS OR INDUSTRY distillery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levi Fishpaw				14. MOTHER'S MAIDEN NAME Maria Sheeler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO.		17. INFORMANT Hilda T. Fishpaw		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO (b) Hypertensive Cardiovas. Dis. DUE TO (c) 15y. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH 7 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PERNICOUS ANAEMIA						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 10, 1938 to Mar 2, 1961 that (I) (we) last saw the deceased alive on Mar 1, 1961 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Clifford F. Hudson				22b. DATE SIGNED Mar 2, 1961		22c. PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON	
22d. ADDRESS FORK, MD.		22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-6-61		23c. NAME OF CEMETERY OR CREMATORY Jessop Methodist		23d. LOCATION (City, town or county) (State) Sparks, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.				25a. REC'D BY REGISTRAR DATE MAR 9 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kenna	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02708

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FULLERTON</u> c. LENGTH OF STAY IN b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>FULLERTON-NURSING HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> d. STREET ADDRESS <u>601 PICCADILLY RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANNA</u> First Middle Last <u>FEMALE</u> 4. DATE OF DEATH <u>MARCH 19 1961</u> Month Day Year		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>AUG-4 1881</u> Yrs. Months Days		9. AGE (In years last birthday) <u>79</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>GERMANY</u> 11. BIRTHPLACE (County & State, or foreign country) <u>USA NATURALIZED</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA NATURALIZED</u>			
13. FATHER'S NAME <u>FRANK ADER</u> 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> 17. INFORMANT <u>CHARLES M. FLANAGAN</u> Address <u>TOWSON</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EXSANGUINATION (INTO BOWEL)</u> DUE TO (b) <u>MASSIVE INFARCTION OF BOWEL</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>ARTERIOSCLEROTIC HEART DISEASE</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>TOWSON</u>		20g. (County) <u>TOWSON</u>		20h. (State) <u>M.D.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1/15 1960</u> to <u>3/19 1961</u> , that (I) (we) last saw the deceased alive on <u>3/19 1961</u> and that death occurred at <u>9:40 A.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Donald L. Somerville</u> 22c. PHYSICIAN'S NAME (Type) <u>DONALD L. SOMERVILLE, M.D.</u>		22b. ADDRESS <u>25 W. PENNA AVE, TOWSON 4, MD.</u>		22d. DATE SIGNED <u>3/19/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-22-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD</u>	
23d. LOCATION (City, town or county) <u>WHEELING WEST VIRGINIA</u>		23e. (State) <u>MD</u>		23f. (Country) <u>USA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. M. Cook - Towson, Inc.</u>		24a. ADDRESS <u>1050 YORK RD - TOWSON</u>		24b. DATE <u>MAR 21 '61</u>	
25a. REC'D BY REGISTRAR <u>Charles S. Kenna</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kenna</u>		25c. DATE <u>MAR 21 '61</u>	



FOR STATE
HEALTH DEPT.

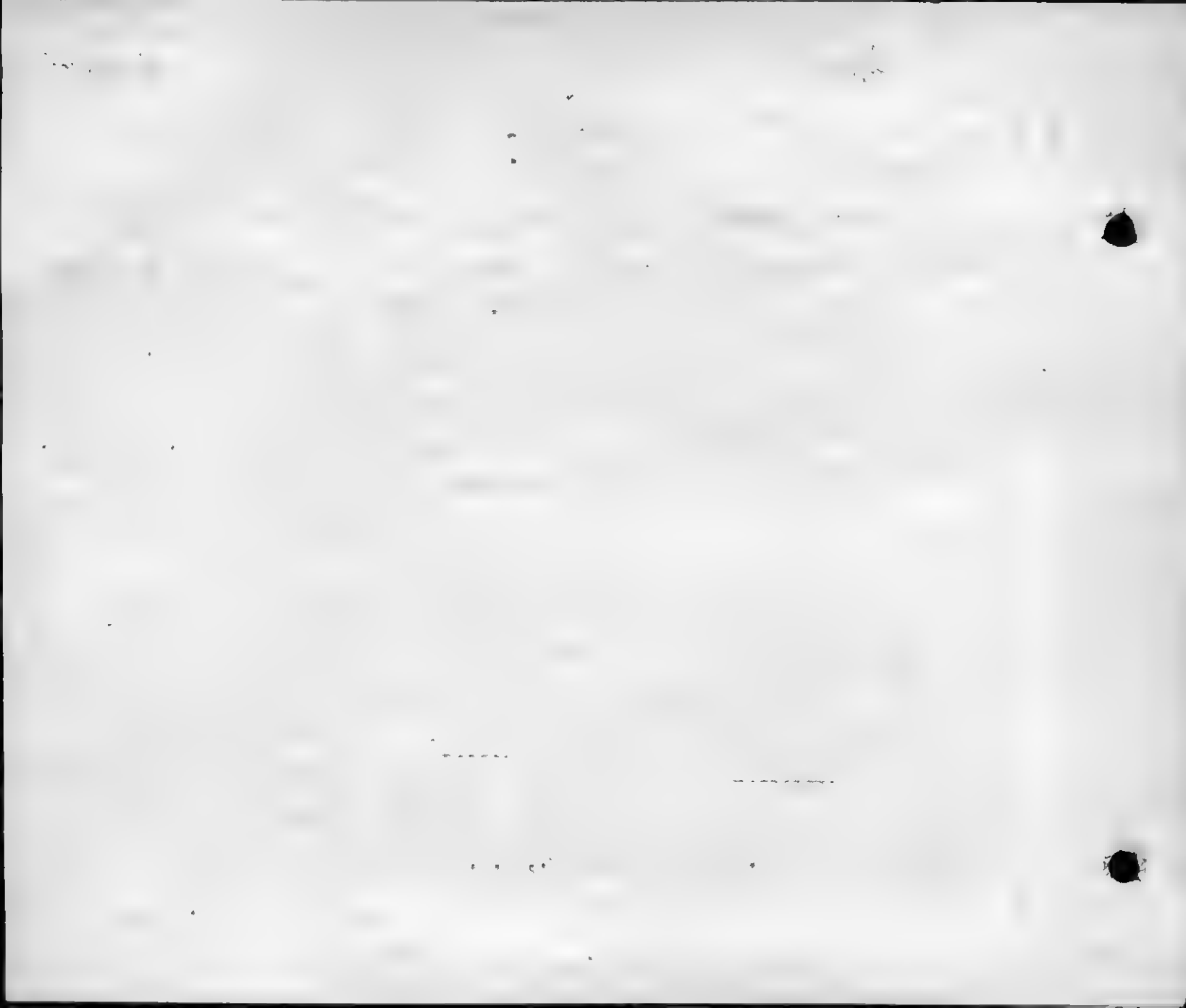
TO DIRECTOR: This certificate should be executed within 24 hours after death. If necessary, it may be extended by the State Board of Health. It should be forwarded to the Chief Medical Examiner's Office along with form PM-3, Page 5, and retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2723 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02709									
1. PLACE OF DEATH a. COUNTY BALTIMORE					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glyndon					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glyndon				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 11 Central Avenue					d. STREET ADDRESS 11 Central Avenue				
3. NAME OF DECEASED (Type or print) TIMOTHY JOHN FLORENTINA					4. DATE OF DEATH Month March Day 14 Year 19 61				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH Feb. 12, 1961				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					11. BIRTHPLACE (State or foreign country) Baltimore, Md.				
10b. KIND OF BUSINESS OR INDUSTRY None					12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME Francis Florentina					14. MOTHER'S MAIDEN NAME Margaret M. Tierney				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. None				
17. INFORMANT Francis Florentina, 11 Central Ave. Glyndon, Md.					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
DATE SIGNED 3/15/61									
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.									
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
22b. DATE THEREOF March 15, 1961									
22c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery									
22d. LOCATION (City, town, or country) (State) Reisterstown, Md.									
23. FUNERAL DIRECTOR J.F. Fline & Sons, Reisterstown, Md.									
ADDRESS									
24a. REC'D BY REGISTRAR MAR 17 '61									
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus									

2-44346XV6



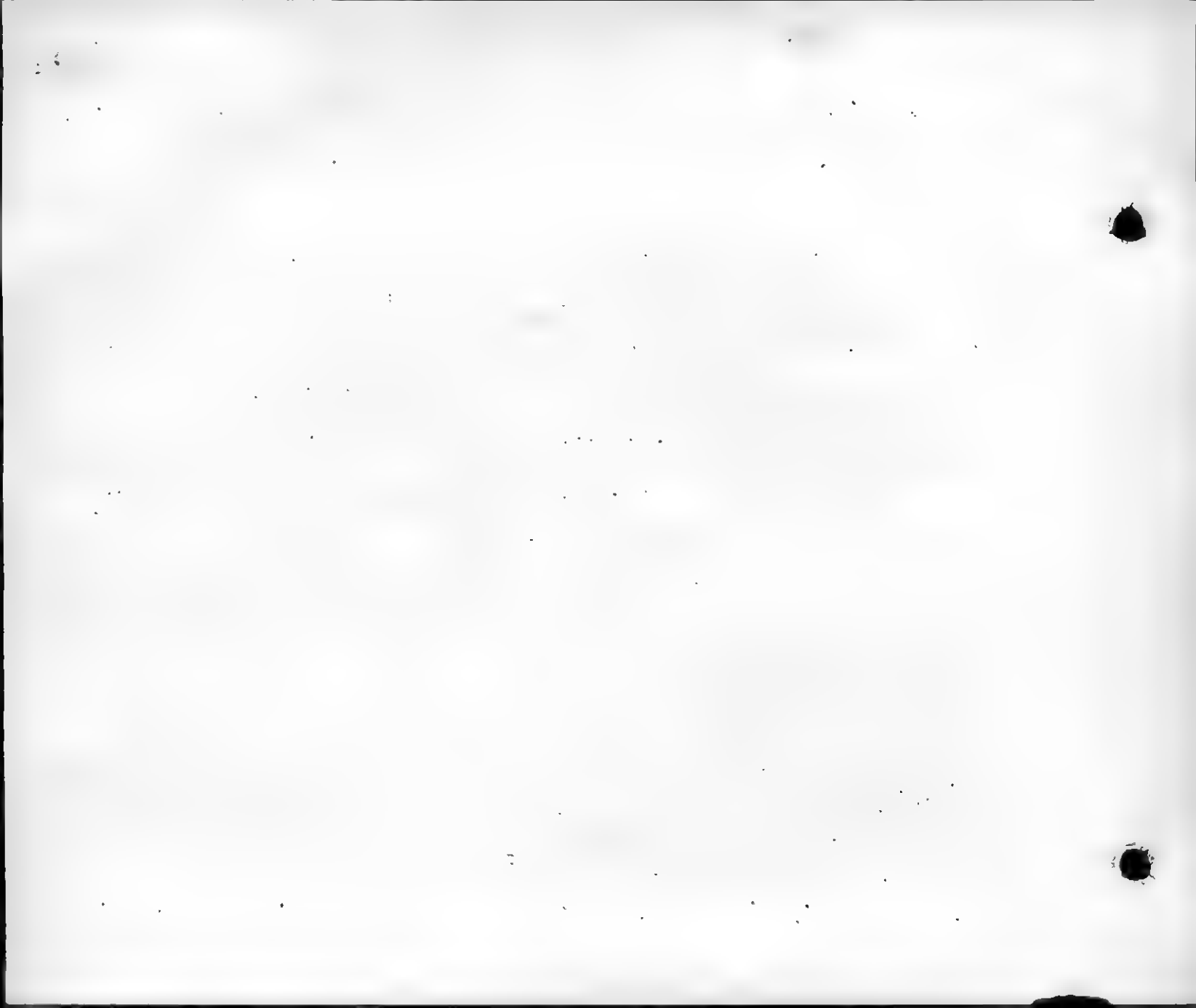
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2730 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No. 02710

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>		c. LENGTH OF STAY IN lb <u>38 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ADA LOKER FRANCIES</u>		4. DATE OF DEATH Month Day Year <u>march 11 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 7 1894</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Fallston Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A. Loker</u>		14. MOTHER'S MAIDEN NAME <u>Laura Benbow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-34-0140</u>	
17. INFORMANT <u>William T.M. Frances</u>		Address <u>Baldwin Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Diabetes</u> DUE TO (b) <u>Diabetes</u> DUE TO (c) <u>Diabetes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>yes</u> <u>6</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 14, 1923</u> to <u>Mar 11, 1961</u> , that I last saw the deceased alive on <u>Mar 11, 1961</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter McHammett</u> M.D.		ADDRESS (Street, city or town, state) <u>Baldwin</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Walter McHammett</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/14/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Naugh Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Stenn Arm. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Futz</u> ADDRESS <u>Jarrettsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 15 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

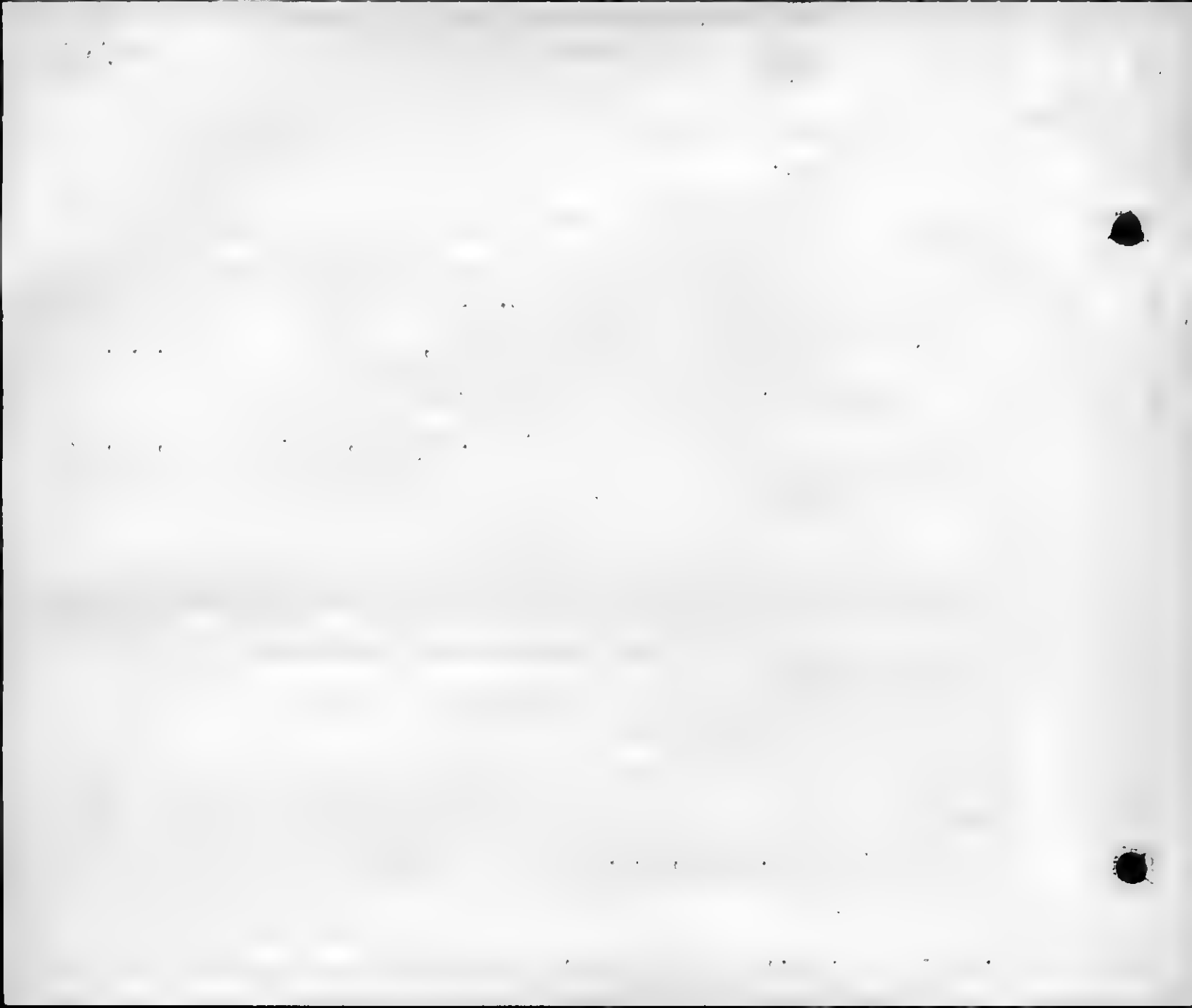
Reg. Dist. No. **02712**

2731

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Fullerton	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. LENGTH OF STAY IN 1b Fullerton (Fullerton)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 24 Bangert Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Friesser Last Friesser		4. DATE OF DEATH Month March Day 18 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1876
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Marburg, Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mathias Friesser		14. MOTHER'S MAIDEN NAME Theresia Traxler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Julius M. Friesser, 24 Bangert Ave, Fullerton		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition, Senility DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Insufficiency Congestive failure DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 59 , to March , 19 61 , that I last saw the deceased alive on March 16 1961 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William A. Tyson M.D.		ADDRESS (Street, city or town, state) Kingsville, Md. DATE SIGNED 3-18-61	
PHYSICIAN'S NAME (Type) William A. Tyson, M.D.		Kingsville, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 3-20-61	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Grand Rapids, Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road, Towson		ADDRESS	
24a. REC'D BY REGISTRAR MAR 21 '61		24b. REGISTRAR'S SIGNATURE Wm. S. Friess	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2732

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02713

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b X Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1037 Beechfield Avenue		e. STREET ADDRESS 1037 Beechfield Avenue	
3. NAME OF DECEASED (Type or print) First Frederick Middle F. Last Fritzges		4. DATE OF DEATH Month March Day 27 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1886
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY B & O R.R.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John A. Fritzges		14. MOTHER'S MAIDEN NAME Margaret Sussen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO AAA	
17. INFORMANT Katherine Fritzges		Address 1037 Beechfield Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chor Myocarditis 422.1 DUE TO De compensation Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO General Arterio Sclerosis (c) Parkinson Syndrome PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Parkinson Syndrome		INTERVAL BETWEEN ONSET AND DEATH 6 mo 2 mo 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter note of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1960 to March 27, 1961 , that (I) (we) last saw the deceased alive on March 26, 1961 , and that death occurred at 4 A.M. from the causes and on the date stated above.			
22a. SIGNATURE B. Bruce Brumbaugh, M. D.		22b. DATE SIGNED 3/28/61	
22c. PHYSICIAN'S NAME (Type) B. Bruce Brumbaugh, M. D.		22d. ADDRESS 5609 Main St. Elkridge 27, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/29/61	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR DATE MAR 30 '61	
ADDRESS 4107 Wilkens Avenue		25b. REGISTRAR'S SIGNATURE Wm S. Thoma	



2733

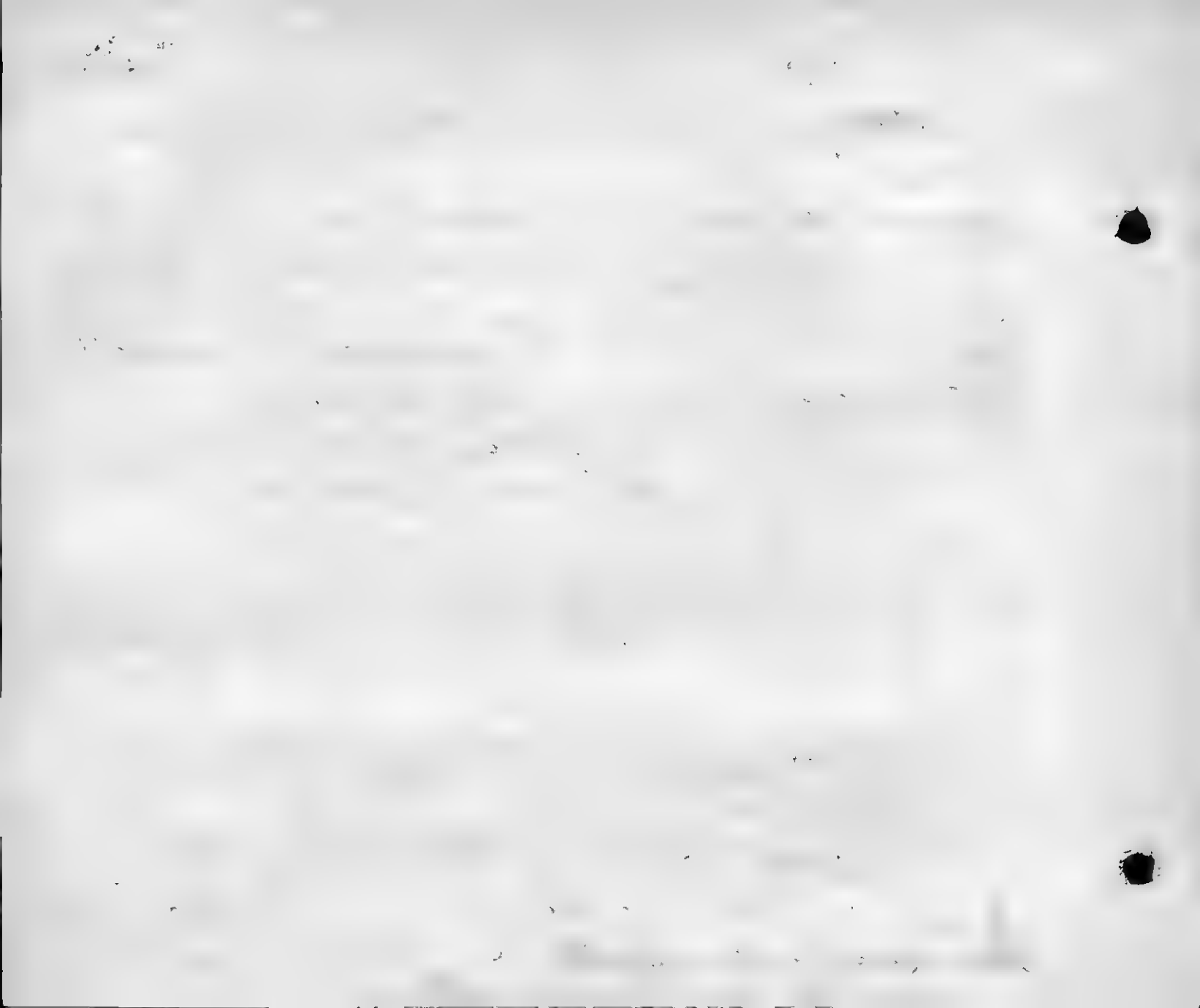
02714

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5431 Price Ave</u>	
b. <u>Garrison</u> write RURAL and give nearest town)		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Foxleigh Conv Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SARA</u> Middle <u>GABER</u> Last <u>GABER</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22 1901</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Not known</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>Julius Gaber - same</u>	
17. INFORMANT <u>Julius Gaber - same</u>		Address	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) <u>192.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>BRAIN Tumor (glioblastoma)</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary artery disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>MARCH 14, 1961</u> , that (I) (we) last saw the deceased alive on <u>MARCH 7, 1961</u> , and that death occurred at <u>9:45</u> PM, from the causes and on the date stated above			
22a. SIGNATURE <u>Leonard Kotz</u>		22b. DATE SIGNED <u>3/14/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEONARD KOTZ, M.D.</u>		22d. ADDRESS <u>6819-Beekmont Rd Balto 15 Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-15-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>		23d. LOCATION (City, town or county) (State) <u>Balto Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Lewis Inc 2100 Euston Pl</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 16 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hunt</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
158 9/60



may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2734

02715

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale				c. LENGTH OF STAY IN lb Rockdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3512 Rolling Rd. Balto. 7				d. STREET ADDRESS 3512 Rolling Rd. Balto. 7			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mr. Charles Middle W. Last Garrison				4. DATE OF DEATH Month March Day 7 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 7, 1877	
9. AGE (In years last birthday) 83 yrs		IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min 83		IF UNDER 24 HRS. Months 83 Days 83 Hours 83 Min 83			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Construction Foreman-C&P Tel.Co.				10b. KIND OF BUSINESS OR INDUSTRY Foreman-C&P Tel.Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John W. Garrison				14. MOTHER'S MAIDEN NAME Phoebe Paul			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 212-05-0939		17. INFORMANT Mrs. Evelyn M. Garrison, 3512 Rolling Rd. Balto. 7.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X Congestive Heart Failure DUE TO (b) Bundled Asthma - Emphysema DUE TO (c) lying cause last.				INTERVAL BETWEEN ONSET AND DEATH 10 Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCT 7, 1954 to March 7 19 61 , that (I) (we) last saw the deceased alive on March 6, 19 61 , and that death occurred at 8:25 PM , from the causes and on the date stated above.							
22a. SIGNATURE Edwin Pierpont				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/7/61	
22c. PHYSICIAN'S NAME (Type) Dr. Edwin Pierpont				22d. ADDRESS 8204 Liberty Rd. Baltimore 7, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-10-1961		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers				25a. REC'D BY REGISTRAR 8728 Liberty Road Randallstown, Md.		25b. REGISTRAR'S SIGNATURE William L. Pinner	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G282 3-14-61 et

CERTIFICATE OF DEATH

Reg. Dist. No.

02716

2735

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>3 V-1-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SHADE NOOK HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William E. Getz</u>		4. DATE OF DEATH <u>MARCH 4</u> 19 <u>61</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/24/1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MOTORMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO TRANSIT CO</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM E. GETZ</u>		14. MOTHER'S MAIDEN NAME <u>MARY DELSCHER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>3316</u>	
17. INFORMANT <u>Mrs. ALLEN W. GETZ</u>		Address <u>BALTO, NAT. PIKE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO (b) <u>Arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1930</u> to <u>3/4</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>3/4</u> , 19 <u>61</u> , and that death occurred at <u>8:15</u> M., from the cause and on the date stated above.			
ACTUAL SIGNATURE <u>Danman M. Magico</u> M.D.		ADDRESS (Street, city or town, state) <u>3316 Frederick St</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/6/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Truman Schwab Frederick Ave.</u>		ADDRESS <u>3512</u>	
24a. REC'D BY REGISTRAR <u>MAR 6 1961</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

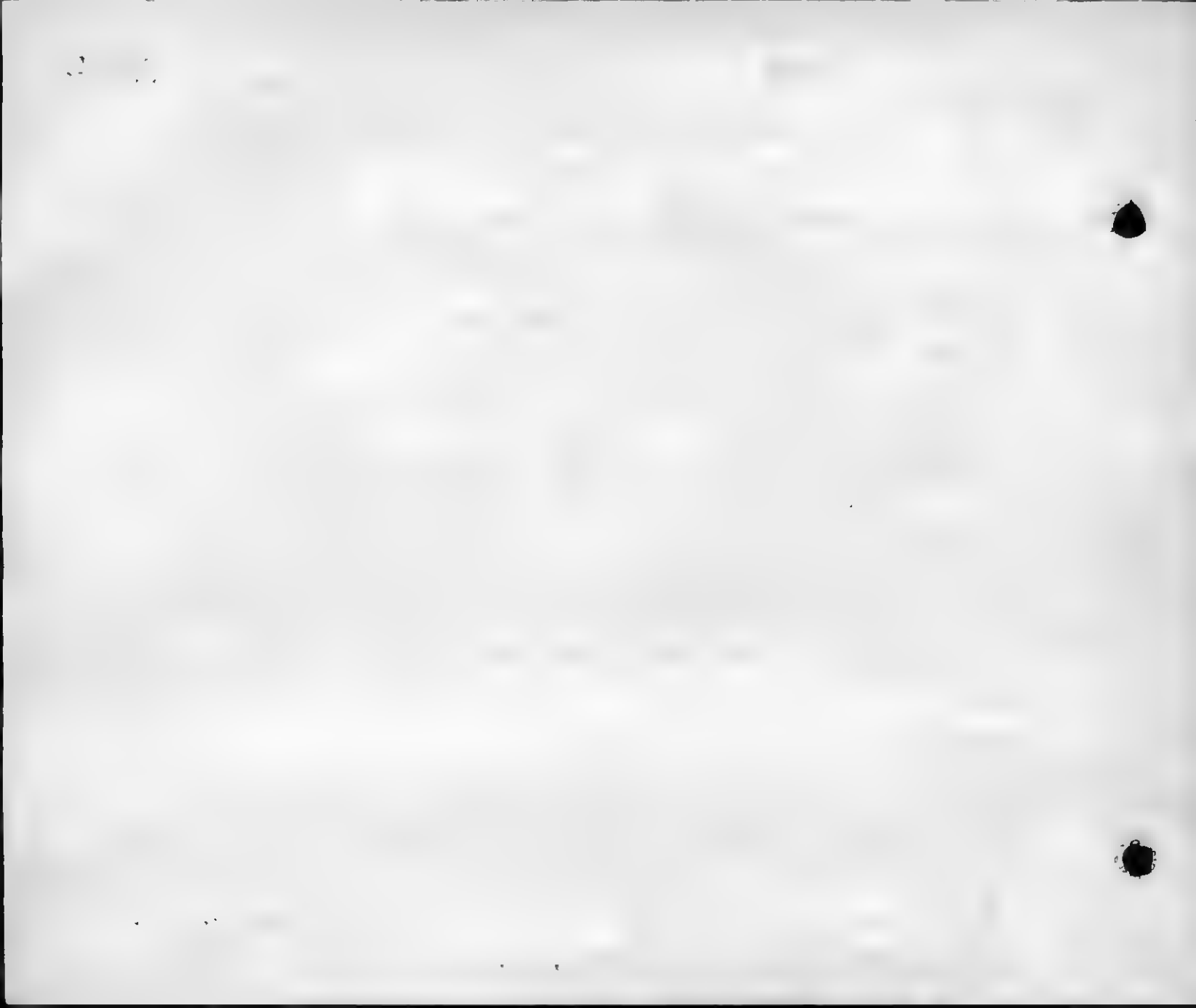
CERTIFICATE OF DEATH

2736

02717

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN b. <u>14 yrs 1m 25d.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>3009 DAR HILL AVE</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ERNEST GIBBONS</u> 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>SEPT 4, 1916</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>44</u> yrs.		4. DATE OF DEATH <u>MARCH 17 1961</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE AGENT</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK GIBBONS</u> 14. MOTHER'S MAIDEN NAME <u>MAUDE MARINER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u> 16. SOCIAL SECURITY NO. <u>214-26-3476</u> 17. INFORMANT <u>RECORDS: SPRING GROVE STATE HOSP.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>March 17</u> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 17</u> , 19 <u>61</u> to <u>March 17</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>March 17</u> , 19 <u>61</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Jose R. Arizaga</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>JOSE R. ARIZAGA, M.D.</u>		22b. DATE SIGNED ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3/19/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cemetery</u> 23d. LOCATION (City, town or county) <u>Somerset Co., Md.</u> (State)	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley, Glen Burnie, Md.</u> ADDRESS		25a. REC'D BY REGISTRAR <u>MAR 21 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director. After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director. After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director. After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

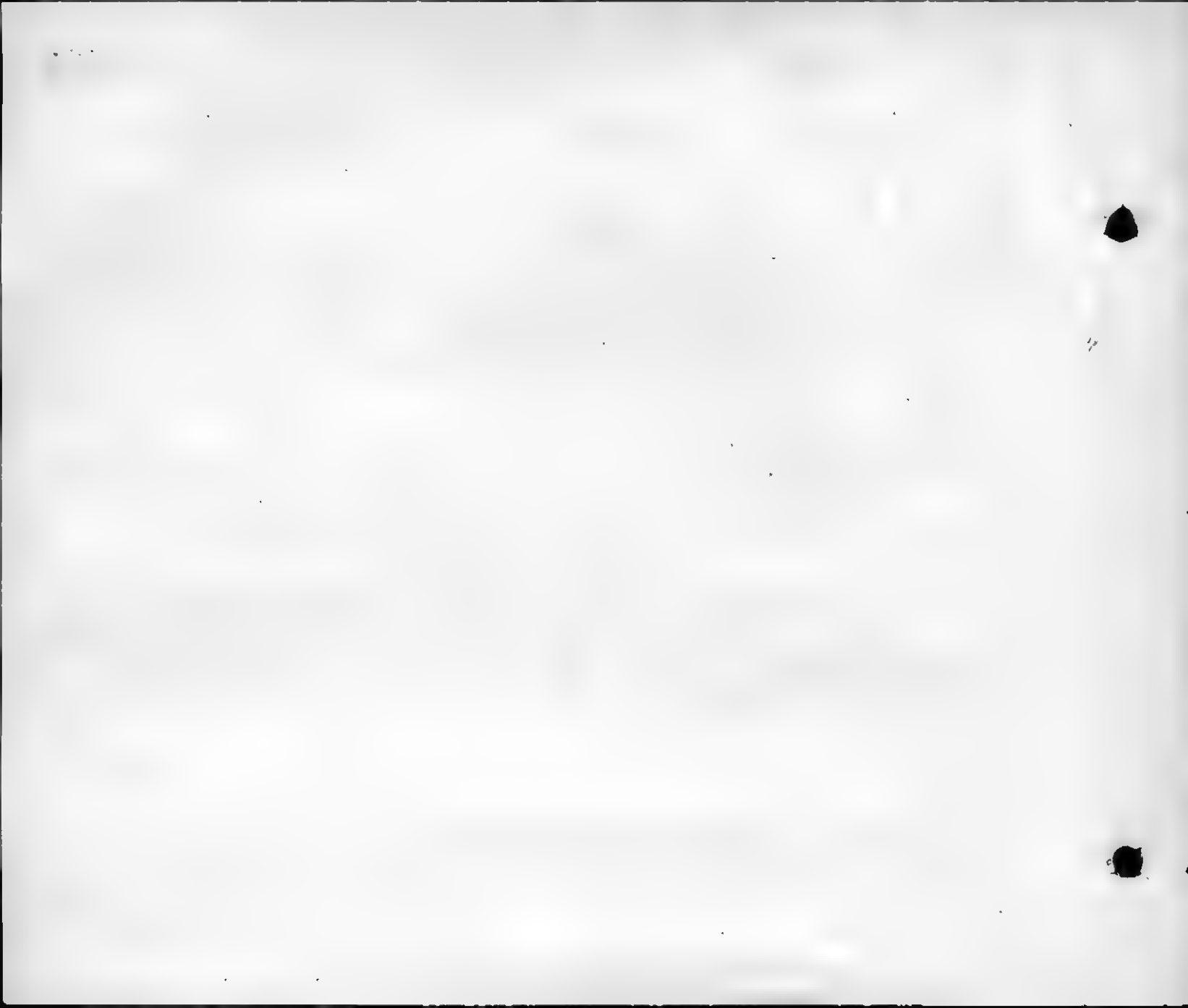
CERTIFICATE OF DEATH

Reg. Dist. No. 02718

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boring</u>		c. LENGTH OF STAY IN 1b <u>2.5 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital give street address)		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>JOVA - E - GILL</u>		4. DATE OF DEATH <u>March 16 1961</u>	
5. SEX <u>MA</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 25 - 1894</u>
9. AGE (In years last birthday) <u>66</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>W Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John R. Roney</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Meyers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>311-11-1111</u>	
17. INFORMANT <u>E Ross Gill, Boring W Va</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma - lung - left</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>163X</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 17, 1961</u> to <u>March 16, 1961</u> , that I last saw the deceased alive on <u>March 15, 1961</u> , and that death occurred at <u>1:35 PM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Clarence E. McWilliams</u> M.D. <u>11904 Leontine Rd, Baltimore, Md</u>		DATE SIGNED <u>March 16, 1961</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-19-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Balto MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Eckel & Kipton</u>		24a. REC'D BY REGISTRAR <u>Mar 20 '61</u>	
ADDRESS <u>Transfected Wd</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form IM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

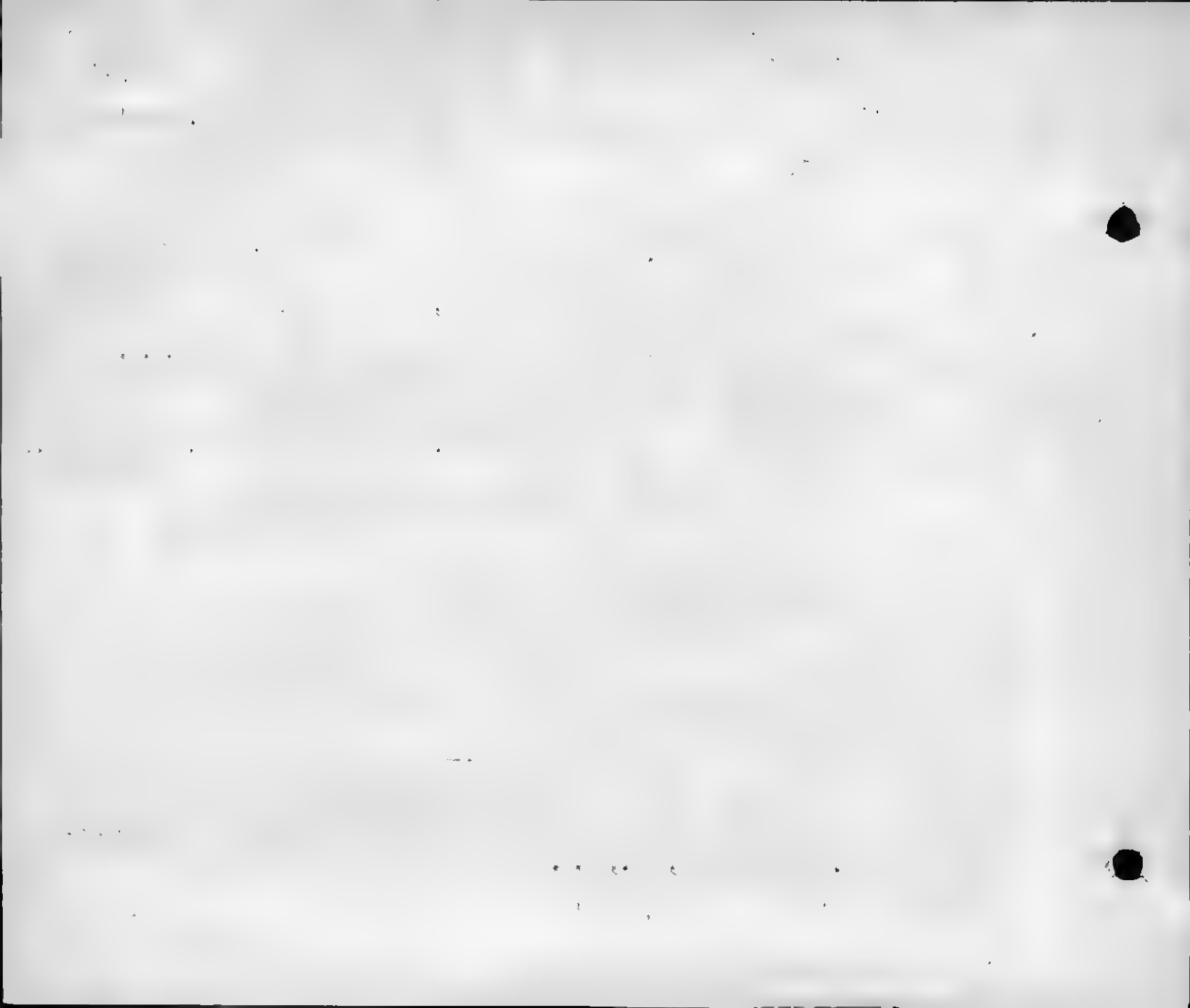
Reg. Dist. No. **02719**

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 207 Margaret Avenue Zone 21		e. STREET ADDRESS 207 MARGARET AVE, #21.	
3. NAME OF DECEASED (Type or print) Lillian First Middle Last GRAYSON		4. DATE OF DEATH 3 25 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 24, 1894
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK	11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH S. HOLSTON	
14. MOTHER'S MAIDEN NAME EMILY ?		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 215-16-5450		17. INFORMANT BERTHA E. COOK Address 3306 MUELLER ST. BALTO., 24, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 170.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 170.1 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 MIN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Jack Collins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JACK COLLINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-29-61	22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.
22d. LOCATION (City, town, or county) BALTO., CO., MD.		22e. LOCATION (City, town, or county) BALTO., CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Geiler ADDRESS 901 S. CONKLEING ST. BALTO., 24, MD.		24a. REC'D BY REGISTRAR MAR 27 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	



TO DEPARTMENT OF HEALTH
1
FOR STATE
HEALTH DEPT.
If delay is necessary, file this certificate with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.
Please file this certificate with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 File 283 3-27-61 MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2739 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02720									
1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN TOWN 1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's P. Geo.	
3. NAME OF DECEASED (Type or print) JAMES A. GREENWELL		4. DATE OF DEATH Month March Day 10 Year 19 61		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6. DATE OF BIRTH Month March Day 12 Year 1928		7. AGE (In years last birthday) 32 yrs.	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 12, 1928		9. AGE (In years last birthday) 32 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Joseph Greenwell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Ralph E. Stanton		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute & Chronic Alcoholism 322.0 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/13/61		22c. NAME OF CEMETERY OR CREMATORY St. John's	
22d. LOCATION (City, town, or country) (State) Hollywood, Md.		23. FUNERAL DIRECTOR ADDRESS W. Clarke Mattingley Leonardtown, Maryland		24a. REC'D BY REGISTRAR DATE MAR 14 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Evans		DATE SIGNED 3/11/61	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2740 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

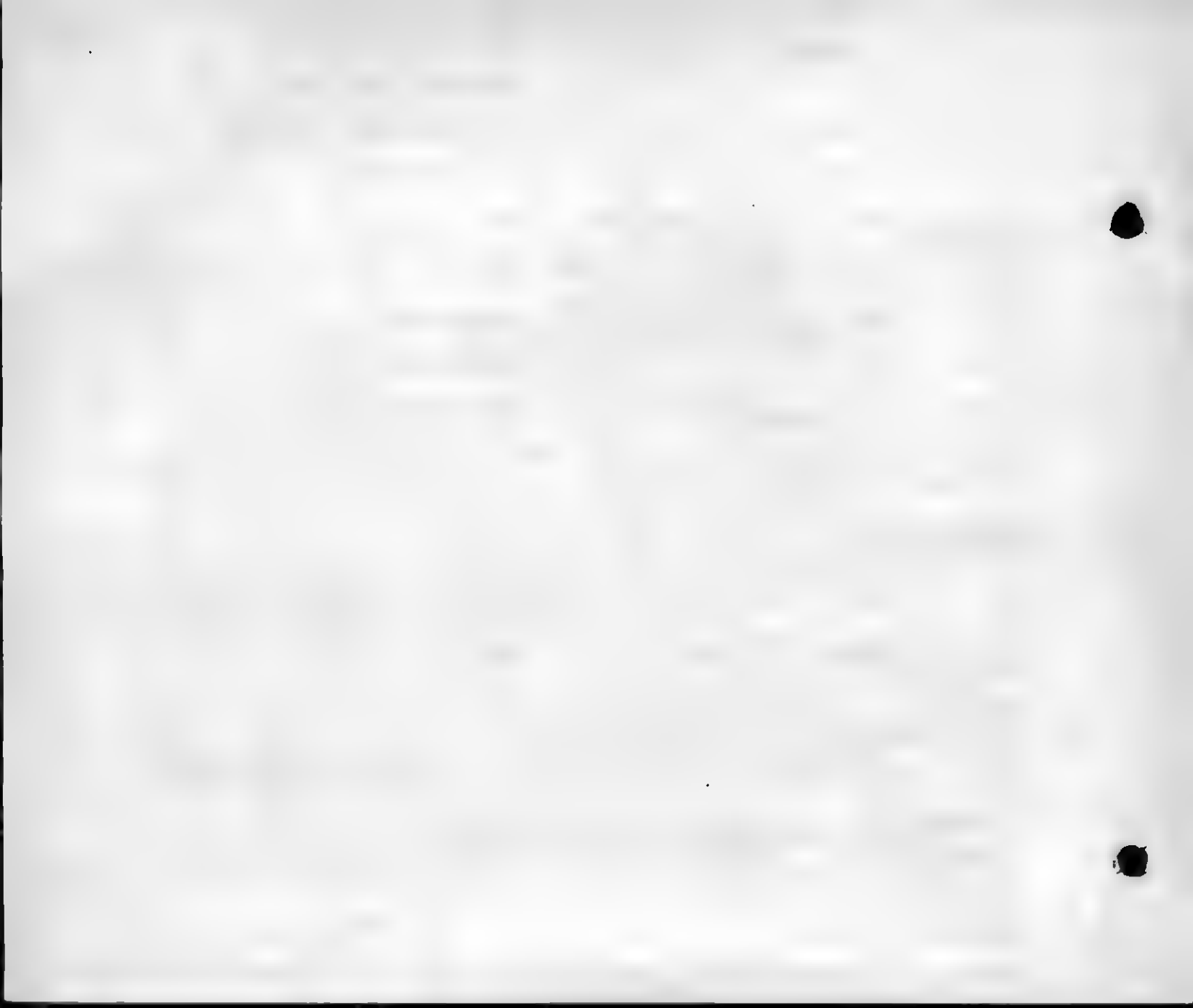
02721

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>10 MO -</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7525 LAWRENCE RD</u>				d. STREET ADDRESS <u>7525 LAWRENCE RD</u>			
3. NAME OF DECEASED (Type or print) First <u>FRANCIS</u> Middle <u>M</u> Last <u>GRETH</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>7</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>MAR 15 - 1885</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>NEW JERSEY</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>WILLARD F. DETACIL</u>			
14. MOTHER'S MAIDEN NAME <u>DOIT KNEW</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>EUGENE H. GRETH</u> Address <u>7525 LAWRENCE RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A-S-C-V - Disease</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M. B. DAVIS</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. DAVIS - M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>3/8/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/9/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DAK LAKE</u>			
22d. LOCATION (City, town, or county) <u> </u>		(State) <u> </u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>LEE RICH FUNERAL HOME DUNDALK</u>				ADDRESS <u> </u>			
24a. REC'D BY REGISTRAR DATE <u>MAR 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give log 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1 FOR STATE HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please file the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used for a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MAY 1961									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2741 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02722									
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 683 S. Avondale Street					d. STREET ADDRESS 683 S. Avondale Street				
3. NAME OF DECEASED (Type or print) WILFORD GRIFFIN					4. DATE OF DEATH Month March Day 5 Year 1961				
5. SEX Male					6. COLOR OR RACE Colored				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 10-2-1914				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Serviceman					10b. KIND OF BUSINESS OR INDUSTRY Cab Co.				
11. BIRTHPLACE (State or foreign country) Petersburg, Va.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME JUNIUS GRIFFIN					14. MOTHER'S MAIDEN NAME UNKNOWN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. UNKNOWN				
17. INFORMANT Mrs Shirley Griffin 683 S. Avondale St.					Address 683 S. Avondale St.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemopericardium 4-1x DUE TO ruptured aorta due to idiopathic medianecrosis of aorta Conditions, if any, which gave rise to immediate cause (b) aorta (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
DATE SIGNED 3/6/61									
ACTUAL SIGNATURE Russell S. Fisher M.D.									
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.									
Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
22b. DATE THEREOF 3-10-61									
22c. NAME OF CEMETERY OR CREMATORY McCalvary Cemetery									
22d. LOCATION (City, town, or country) (State) Anne Arundel Co., Md.									
23. FUNERAL DIRECTOR Randolph J. Collick 1412 E. Preston St.									
24a. REC'D BY REGISTRAR MAR 7 '61									
24b. REGISTRAR'S SIGNATURE William S. Kline									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 1 C, Film G283 3/24/61 iwk

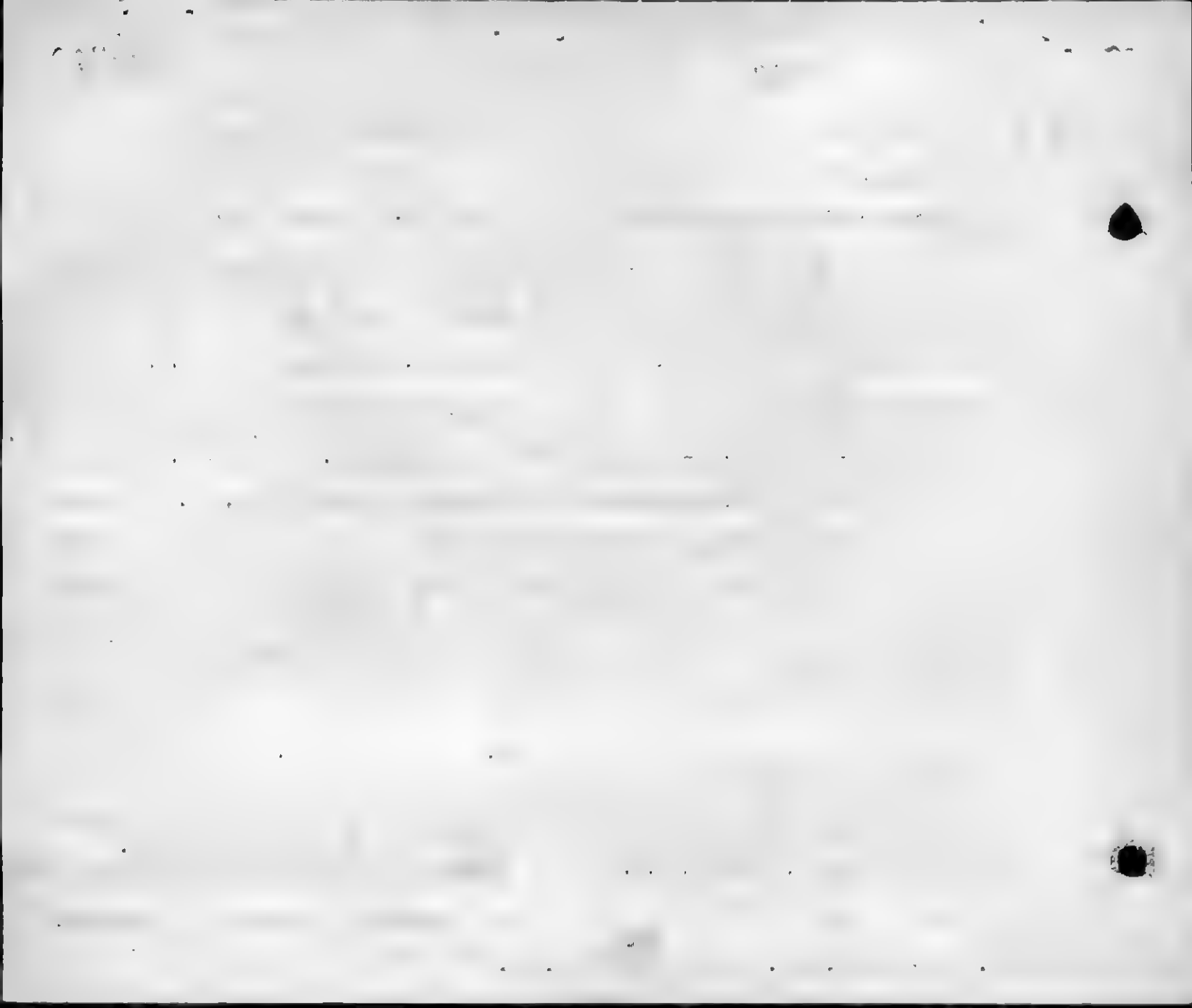
02723

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STRING GROVE HOSP. 2 days</u> c. LENGTH OF STAY (1-1b) <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CATONSVILLE MD.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>P. G.</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4730 HOMER AVE</u> d. STREET ADDRESS <u>SUITLAND, MD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>EDWARD S. GROBAKER</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>17</u> Year <u>1961</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/13/65</u>			
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RET.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>VALENTINE GROBAKER</u>				14. MOTHER'S MAIDEN NAME <u>FRANCES FIELDS</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NO</u>					
17. INFORMANT <u>CALVIN S. GROBAKER</u>				Address <u>SON</u>					
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY ARTERY DISEASE</u> (b) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m.		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
(City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from <u>MAR 15</u> <u>1961</u> , to <u>MAR 17</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>MAR 17</u> <u>1961</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Patrick K. Yip</u>				22b. DATE SIGNED <u>3/18/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>PATRICK K. YIP</u>				22d. ADDRESS <u>% SPRING GROVE STATE HOSPITAL BALTO. MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/21/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE</u>		23d. LOCATION (City, town or county) (State) <u>BALTO. CO. MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>William L. Don - 28</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 20 '61</u>					
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

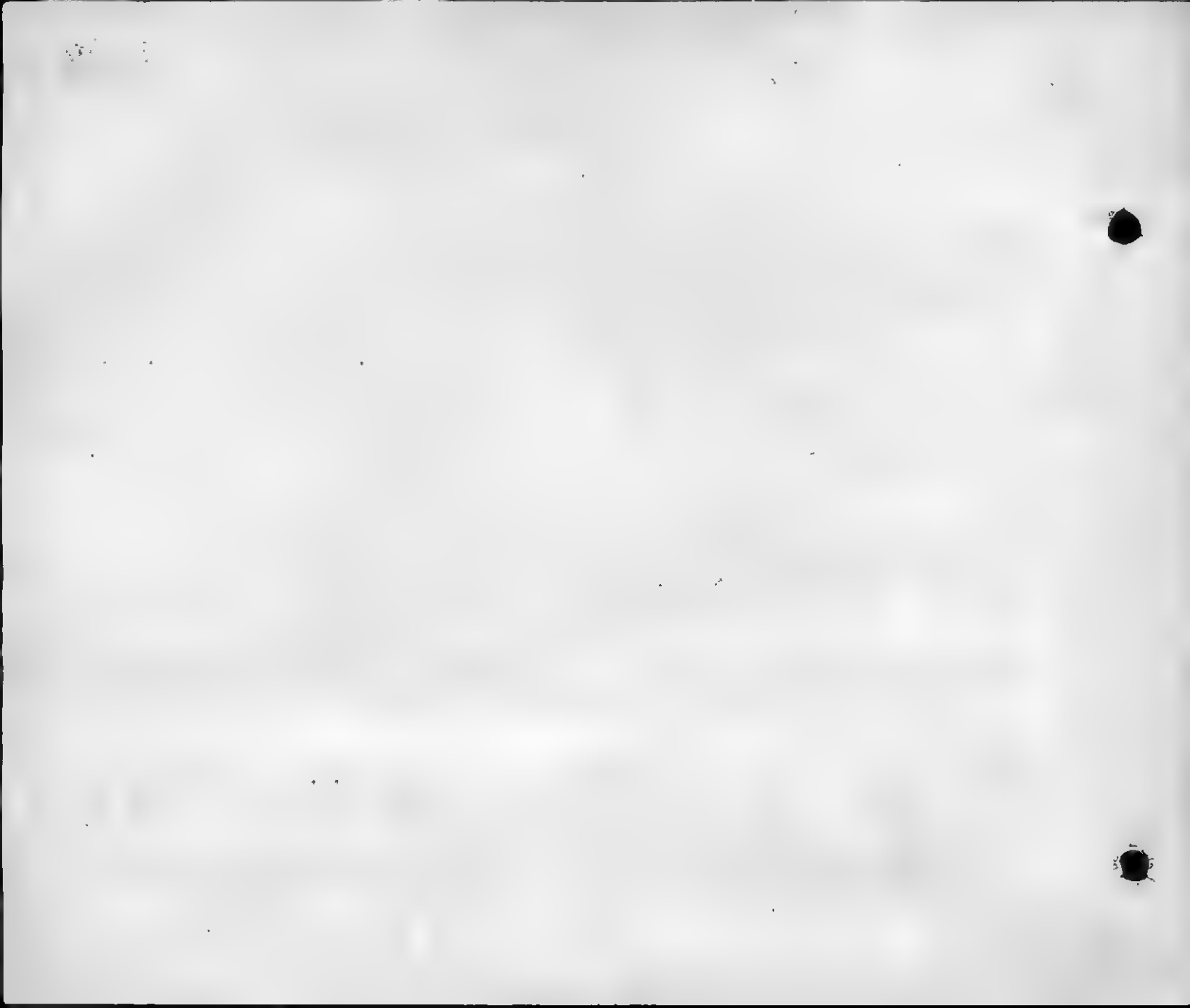
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2744

02725

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN 1b <u>6 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood State Training School</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>722 West Washington Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Randy Lynn Guessford</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>dependent</u> 9. KIND OF BUSINESS OR INDUSTRY <u>none</u> 10. BIRTHPLACE (County & State or foreign country) <u>Washington Co., Maryland</u> 11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		4. DATE OF DEATH <u>3 15 19 61</u> 5. AGE (In years last birthday) <u>2 yrs.</u> 6. IF UNDER 1 YEAR Months Days Hours Min. <u>2</u> 7. IF UNDER 24 HRS. Hours Min. <u>2</u> 8. MOTHER'S MAIDEN NAME <u>Ester Rochell Hawkins</u> 9. SOCIAL SECURITY NO. <u>no</u> 10. INFORMATION <u>Rosewood Records, Owings Mills, Md.</u>	
13. FATHER'S NAME <u>Robert Lee Guessford</u> 14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 15. SOCIAL SECURITY NO. <u>no</u> 16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia and otitis media complicating brain damage</u> DUE TO (b) <u>Damage</u> DUE TO (c) <u>Damage</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>		17. MOTHER'S MAIDEN NAME <u>Ester Rochell Hawkins</u> 18. ADDRESS <u>Rosewood Records, Owings Mills, Md.</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not White</u> <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>5:55</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Dr. W. Rieckert</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. W. Rieckert</u>		22b. DATE SIGNED <u>3-16-61</u> 22d. ADDRESS <u>4307 Mainfield Ave Baltimore</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3-18-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Mem. Garden Hagerstown Md</u> 23d. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Menich</u> ADDRESS <u>Hagerstown, Md.</u> 25a. REC'D BY REGISTRAR <u>MAR 21 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

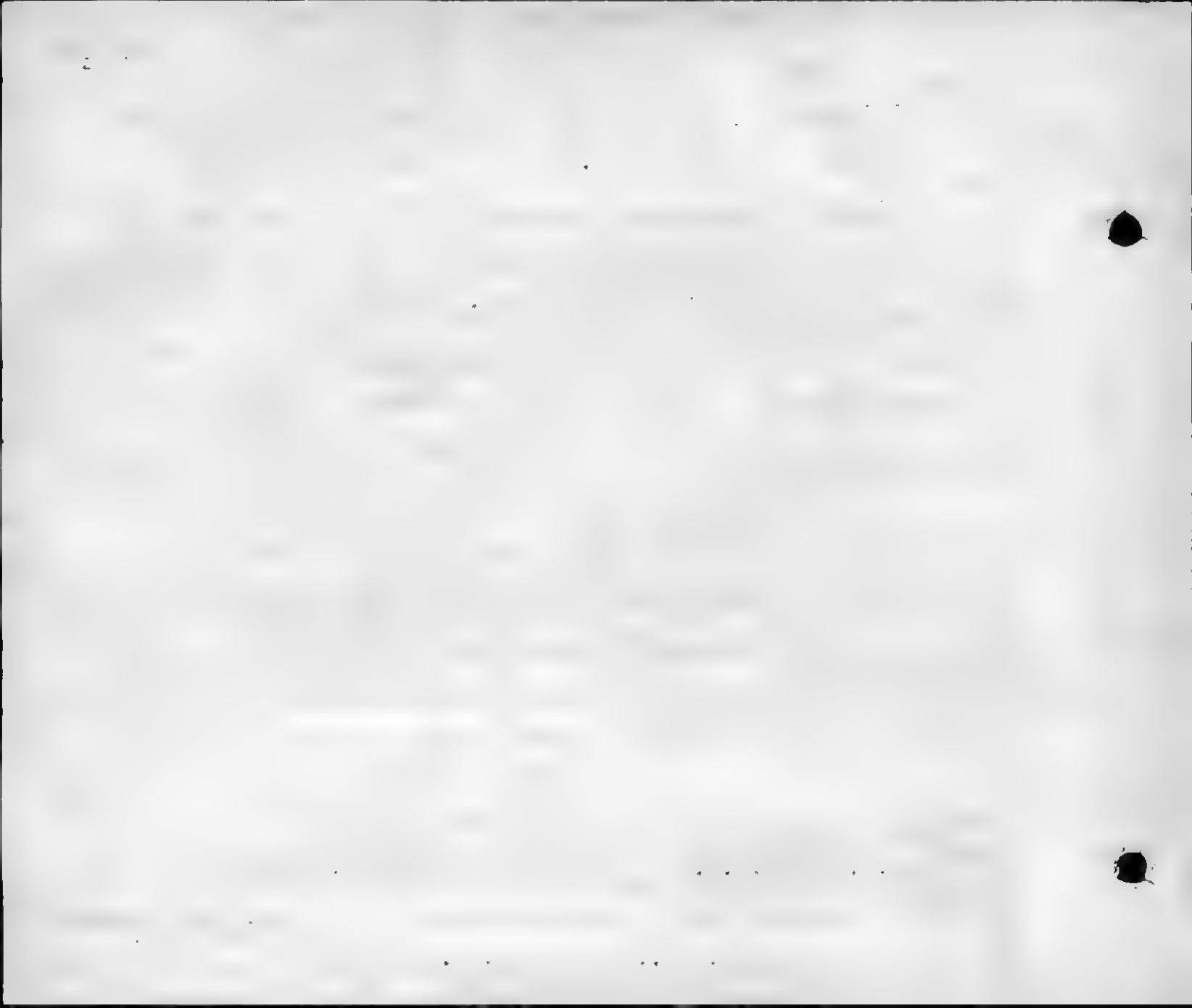
CERTIFICATE OF DEATH

Reg. Dist. No.

02726

2745

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. LENGTH OF STAY IN 1b 19 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 Midway Avenue		e. STREET ADDRESS 11 Midway Avenue	
3. NAME OF DECEASED (Type or print) First IDA Middle +++ Last HALE		4. DATE OF DEATH Month March Day 16th Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1866
9. AGE (In years last birthday) 94		10. IF UNDER 1 YEAR: Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abraham Emborg		14. MOTHER'S MAIDEN NAME Hannah (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address Edna Gochnour same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic edema DUE TO Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1952 to March 1961 , that I last saw the deceased alive on 3-16-1961 , and that death occurred at 8:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2900 Dunran Road DATE SIGNED 3/18/61			
ACTUAL SIGNATURE B.W. Solled		PHYSICIAN'S NAME (Type) B.W. Solled, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/20/61	
22c. NAME OF CEMETERY OR CREMATORY Forest Lawn Memorial		22d. LOCATION (City, town, or county) (State) Johnstown, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md.		24a. REC'D BY REGISTRAR 20 61	
24b. REGISTRAR'S SIGNATURE Arthur S. Howard			



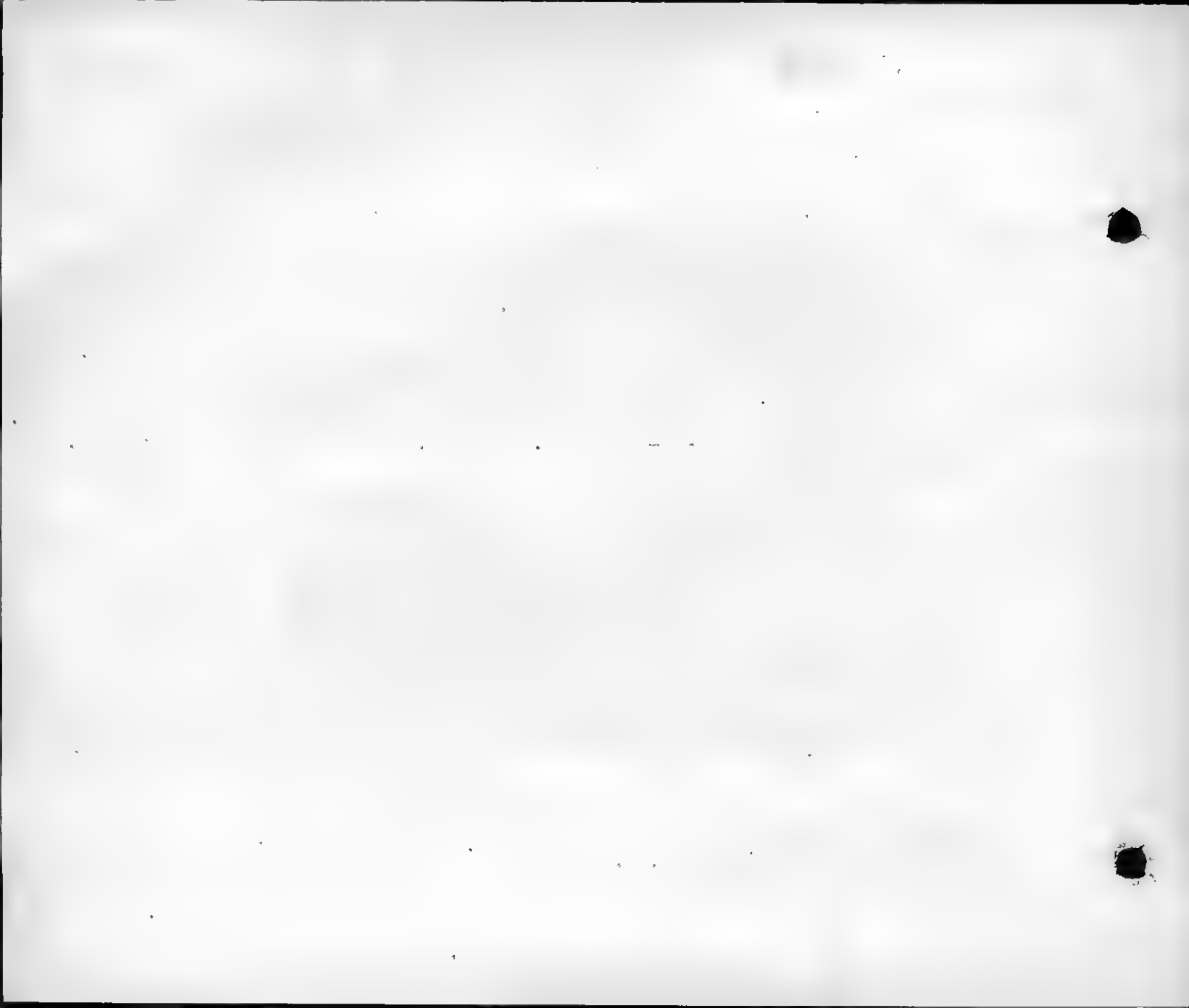
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2746

CERTIFICATE OF DEATH

02727

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainessville</u>		c. LENGTH OF STAY IN 1b <u>4 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1805 E. Joppa Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Bernard</u> Last <u>Hamson</u>		4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 30, 1878</u>
9. AGE (In years last birthday) <u>82</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone mason (repairing for Mill Co.)</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone mason (repairing for Mill Co.)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Hill Hamson</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Louise Stepler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-6171A</u>	
17. INFORMANT <u>Mr. Norman T. Hamson</u>		Address <u>Catonsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized + Coronary</u> lying cause last. (c) <u>arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>March 6, 1961</u> that (I) (the) last saw the deceased alive on <u>March 6, 1961</u> and that death occurred at <u>7 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph F. LiPira</u> M.D.	22b. DATE SIGNED <u>3/7/61</u>	22c. PHYSICIAN'S NAME (Type) <u>Joseph F. LiPira M. D.</u>	
22d. ADDRESS <u>8400 Wood Haven Blvd. Balt 4, Md</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/9/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Eastern Memorial Home</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 8 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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02728
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>2yr26dys</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air, Maryland</u> d. STREET ADDRESS <u>Box 313 - Route #2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Martin</u> Last <u>Handy, Sr.</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1877</u>
9. AGE (in years last birthday) <u>83¹</u>		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Handy</u>		14. MOTHER'S MAIDEN NAME <u>Melissa Margaret Reeves</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-32-3741</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C. V. A. (Cerebral Hemorrhage)</u> DUE TO (b) <u>Arteriosclerotic Aortic Valvular Stenosis</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Cerebral Arteriosclerosis</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 21, 1961</u> to <u>3-4, 1961</u> that (I) (we) last saw the deceased alive on <u>March 4, 1961</u> , and that death occurred at <u>8:55 pm</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>JOSE R. ARIZAGA</u>		22b. DATE SIGNED <u>March 5, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSE R. ARIZAGA</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 8, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		23d. LOCATION (City, town or county) <u>Bel Air Harford Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Conner</u>		25a. REC'D BY REGISTRAR <u>March 10 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>William S. Hearn</u>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

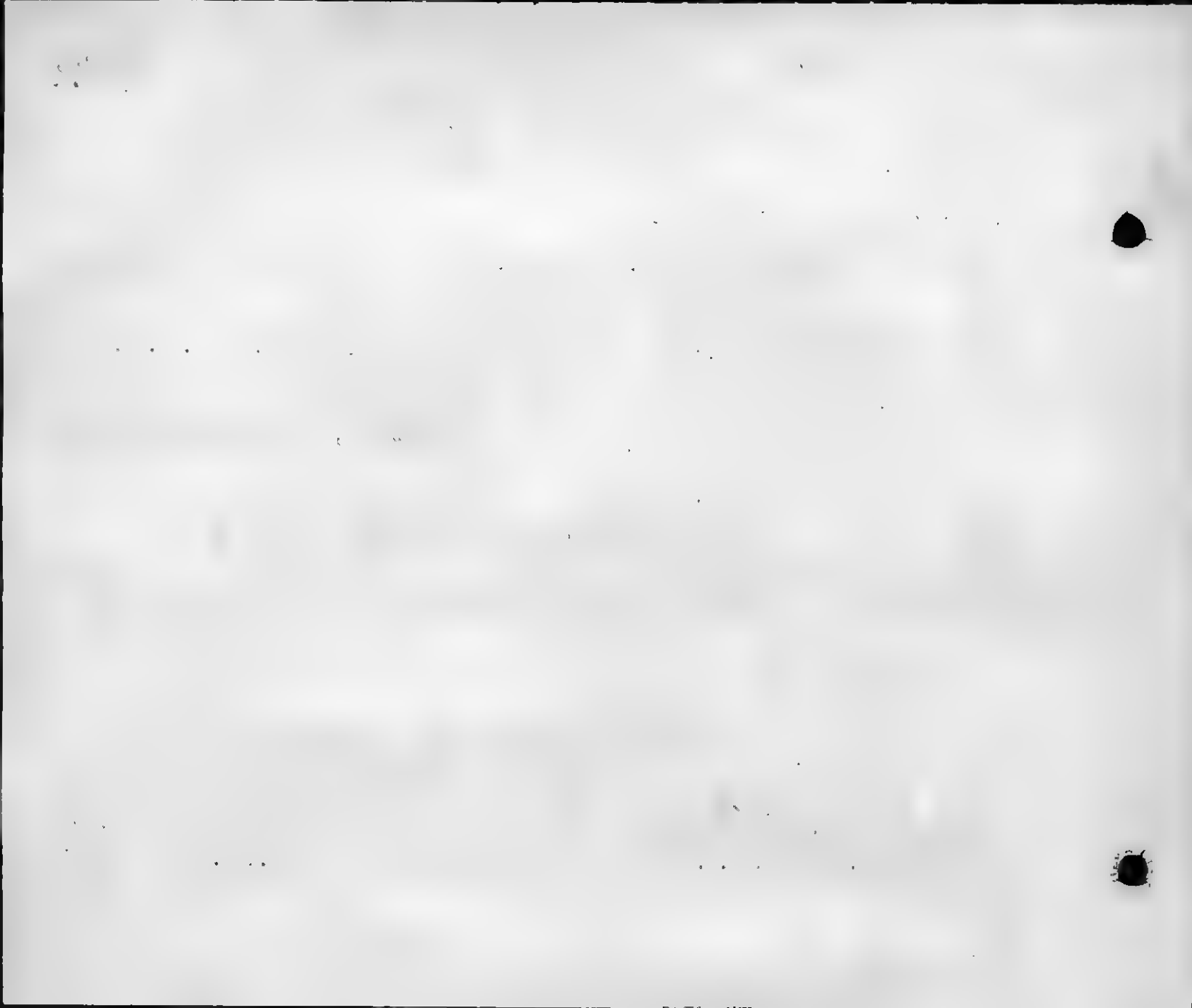
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2748

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02729

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 3 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Centreville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 3, Box 123 d. STREET ADDRESS Route 3, Box 123	
3. NAME OF DECEASED (Type or print) PERRY First Middle Last F. HANDY		4. DATE OF DEATH Month Day Year March 23 19 61	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 11, 1891	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Retired		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Queen Annes County, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Handy		14. MOTHER'S MAIDEN NAME Mary Gould	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 213-24-4813	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland		Address Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO (b) DUE TO HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE Conditions, if any, which gave rise to immediate cause (c) UREMIA DUE TO (b) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 20 8:45 1961 , to March 23 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 23 1961 , and that death occurred at 8:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan		22b. DATE SIGNED 3/24/61	
22c. PHYSICIAN'S NAME THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 3/27/61		23c. NAME OF CEMETERY OR CREMATORY Gouldtown	
24. FUNERAL DIRECTOR'S SIGNATURE James B. Ashwell, Eastern, Md		24b. ADDRESS Centreville, Maryland	
25a. REC'D BY REGISTRAR DATE MAR 29 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

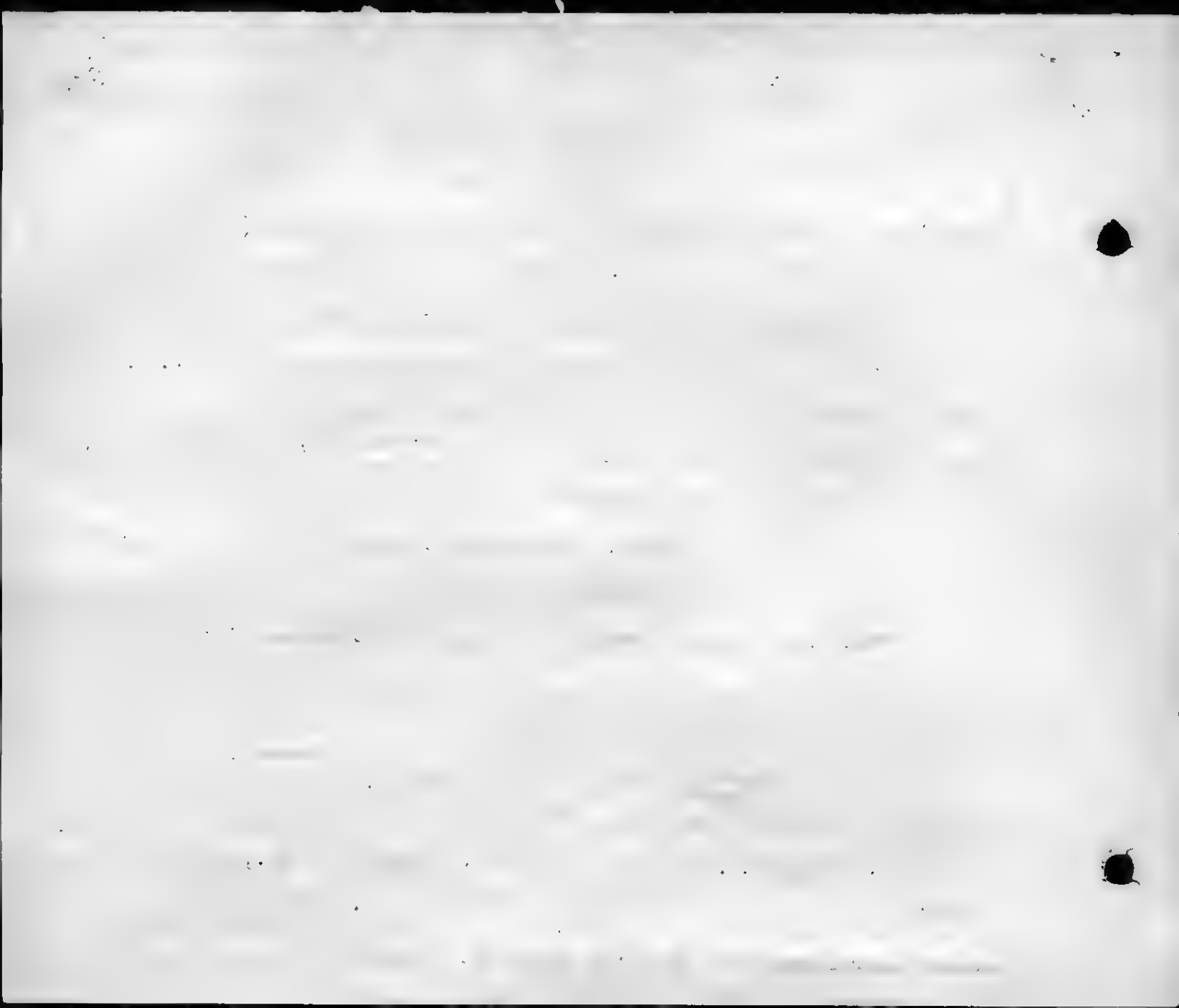
CERTIFICATE OF DEATH

2749

02730

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4228 Belmar Avenue (6)	
3. NAME OF DECEASED (Type or print) HAROLD A. HARRISON		4. DATE OF DEATH Month March Day 23 Year 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 24, 1893
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction		10b. KIND OF BUSINESS OR INDUSTRY Houses - Boats	
11. BIRTHPLACE (County & State, or foreign country) Tilghman, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Isaac A. Harrison		14. MOTHER'S MAIDEN NAME Sarah E. Lowery	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 218-09-0006	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland		17. ADDRESS Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) RECURRENT ADENOCARCINOMA, COLON (a), stating the underlying cause last. DUE TO (c) FECAL FISTULA, Due to (b)			
INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? EMACIATION Duration Unknown- Due to Recurrent Adenocarcinoma (b) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 20, 1961 , to March 23, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 23, 1961 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Thomas F. Crahan</i> 22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22b. DATE SIGNED 3/23/61	
22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 25, 1961	23c. NAME OF CEMETERY OR CREMATORY Tilghman's Meth. Church Cem. Tilghman's Island, Talbot Co., Md.	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home, 7401 Belair Rd. Balto., Md.		25. REC'D BY REGISTRAR MAR 27 '61	
25b. REGISTRAR'S SIGNATURE <i>William S. House</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



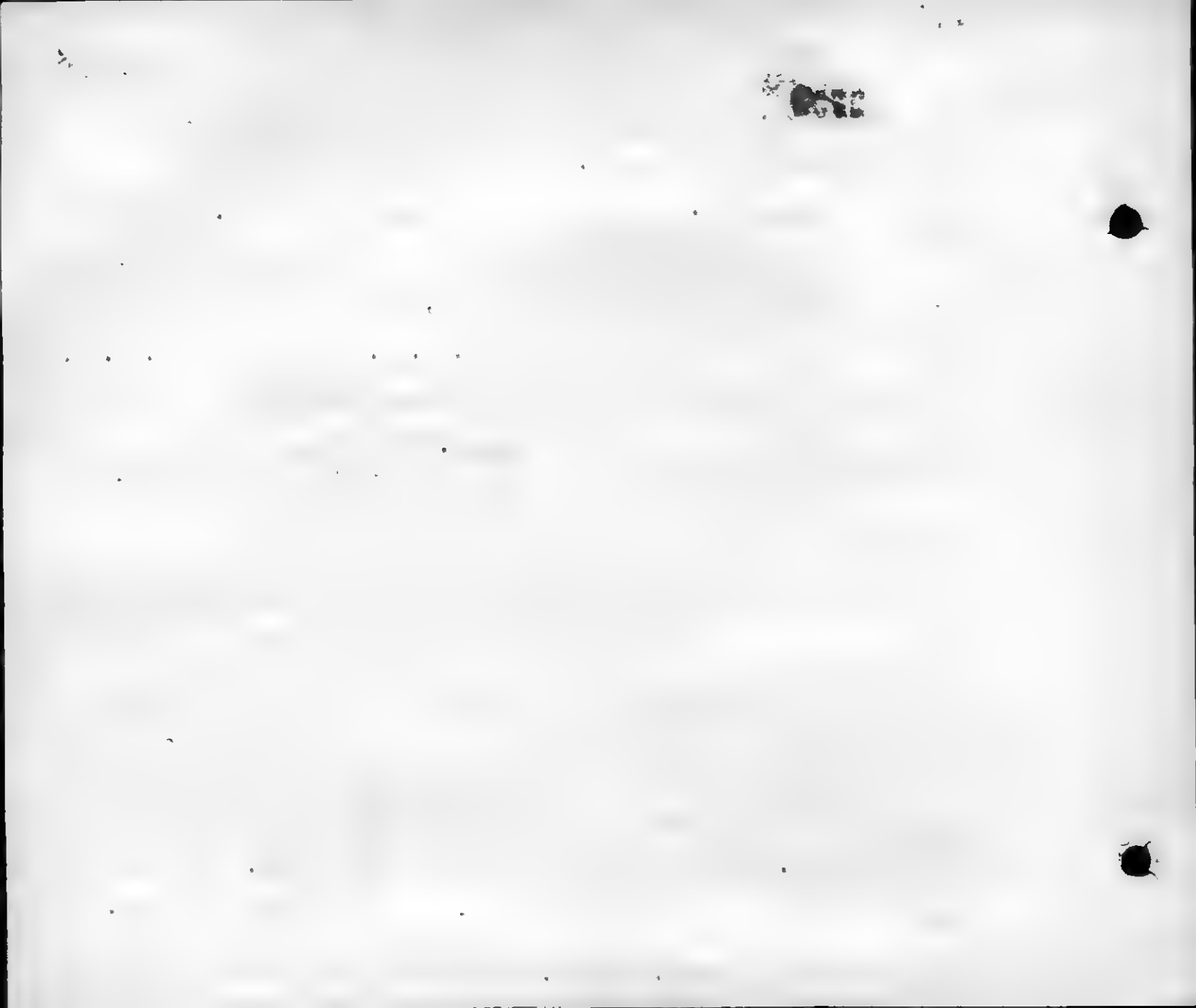
may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

2750

02731

1 PLACE OF DEATH a. COUNTY Baltimore Co. MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe				c. LENGTH OF STAY IN 1b 4 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1101 Flamingo Dr.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Clementine Heckathorn				4. DATE OF DEATH Month Day Year March 10, 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1890	9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.		
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hosewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U. S. A.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Amos James Gregory				14. MOTHER'S MAIDEN NAME Celeste Nunnally			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Amos J. Heckthorn Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c). _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____
21 I certify that (I) (this hospital) attended the deceased from Feb 7, 1961 to 3-10, 1961 that (I) last saw the deceased alive on Feb 12, 1961 , and that death occurred at 8 AM , from the causes and on the date stated above.							
22a. SIGNATURE Earl I. Pass				22b. DATE SIGNED Mar 13 '61		22c. PHYSICIAN'S NAME (Type) Earl I. Pass	
22d. ADDRESS 4001 Wilkens Ave.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/13/61		23c. NAME OF CEMETERY OR CREMATORY Loudon Park cem.		23d. LOCATION (City, town, or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Ambrose				25a. REC'D BY REGISTRAR 1328 Sulphur Spring Rd		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	
ADDRESS Balt. 27, Md.				DATE MAR 13 '61			



may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> <div style="text-align: right; font-size: 1.5em;">02732</div>													
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY _____									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b _____				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House of Pines				d. STREET ADDRESS 4910 Palmer Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) LENA HECKLEMAN				4. DATE OF DEATH Month 3 Day 16 Year 1961									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1883		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Russia				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Abe Cohen						14. MOTHER'S MAIDEN NAME Minnie							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Lillian Klein				Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Disease</i> 4-43X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </div> <div> (b) <i>Chronic Hypertension</i> DUE TO (c) </div> <div> INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> 1571 </div> </div>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>8-25-1959</i> to <i>3-16-1961</i>, that (I) (we) last saw the deceased alive on <i>3-16-1961</i>, and that death occurred at <i>2043 W. 21st</i> from the causes and on the date stated above.													
22a. SIGNATURE <i>William H. Gallagher</i>						22b. DATE SIGNED _____		22c. PHYSICIAN'S NAME (Type) <i>William H. Gallagher</i>					
22d. ADDRESS <i>6209 Proctorville Ave, Balt 28, Md</i>						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 3/17/61		23c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagodol		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS INC.						ADDRESS 6010 Reisterstown Rd.		25a. REC'D BY REGISTRAR MAR 20 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

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070

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TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2252 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02733

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown				c. LENGTH OF STAY IN 1b 15 yrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cherry Hill Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emory Middle A. Last Heiges				4. DATE OF DEATH Month March Day 19 Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1883	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Heiges				14. MOTHER'S MAIDEN NAME Mary E. Arnsberger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 160-16-9838		17. INFORMANT Address Mrs. Anna Bohrer Pigleville, Penna.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic C-V Disease (c) 2 yrs. DUE TO (c) 2 yrs.							INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 22, 61		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Arendtsville Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons				ADDRESS Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE MAR 21 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kimes			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2753

CERTIFICATE OF DEATH

02734

Items 13, 14, 15 Filled 02734

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkville

c. LENGTH OF STAY IN 1b 2919 Church Road

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2919 Church Road

2. NAME OF DECEASED
(Type or print) Johanna First Heinlein Middle Last

3. SEX female 4. DATE OF DEATH 3 Month 14 Day 19 Year 61

5. COLOR OR RACE white 6. MARRIED ☐ NEVER MARRIED ☐ 7. DATE OF BIRTH 6-24-1863

8. AGE (in years last birthday) 97 yrs. IF UNDER 1 YEAR: Months 9 Days 14 Hours 19 Min. 61

9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10b. KIND OF BUSINESS OR INDUSTRY Germany 11. BIRTHPLACE (County & State, or foreign country) United States

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME (First name) Unknown 14. MOTHER'S MAIDEN NAME Katherine (nee-Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown 16. SOCIAL SECURITY NO. Straulau 17. INFORMANT Mrs Madelon Welsh Address same

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arteriosclerotic heart disease
DUE TO (b) Rheumatoid arthritis
DUE TO (c) destruction of the sigmoid

19. INTERVAL BETWEEN ONSET AND DEATH 10 yrs
10 yrs
4 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year March 25, 1961 20d. INJURY OCCURRED March 14, 1961 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) March 14, 1961 20f. (City or town) Baltimore (County) Md. (State)

21. I certify that (I) (the hospital) attended the deceased from March 25, 1961 to March 14, 1961, that (I) (we) last saw the deceased alive on March 14, 1961, and that death occurred at 9:00 AM, from the causes and on the date stated above.

22a. SIGNATURE [Signature] 22b. DATE SIGNED March 17 '61

22c. PHYSICIAN'S NAME (Type) [Signature] 22d. ADDRESS [Signature]

23a. BURIAL, CREMATION, REMOVAL (Specify) burial 23b. DATE THEREOF 3-17-61 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery 23d. LOCATION (City, town or county) Baltimore (State) Md.

24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 25a. REC'D BY REGISTRAR March 17 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

within 24 hours after
filled in by the funeral

TO HO. ge 4 may be retained by the hospital or attending physician.
death. VERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is detached for use as the burial permit. Then please remove carbon --

VR A12
15M 9/

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 23b, Film G283 3/20/61 iwk

02735

1. PLACE OF DEATH
a. COUNTY

BALTIMORE

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE

MARYLAND

b. COUNTY

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

BORT HOWARD

10 DAYS

BALTIMORE

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

VETERANS ADMINISTRATION HOSPITAL

612 W LEE STREET

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

JAMES

HELLER

MARCH

6

19 61

5. SEX

6. COLOR OR RACE

7. MARRIED ☐ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday) IF UNDER 1 YEAR

IF UNDER 24 HRS.

MALE

COLORED

WIDOWED ☐

DIVORCED ☒

AUGUST 20 1899

61

61

61

61

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

PRESS OPERATOR

STANDARD STEEL

COLUMBIA, SOUTH CAROLINA

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

ADAM HELLER

MAGGIE NELLAMS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

YES

WW-11

CLIN REC VAH BALTIMORE MD-Ft HOWARD DIVISION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY;
IMMEDIATE CAUSE (a)

BRONCHOPNEUMONIA

1 DAY

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

CEREBRAL VASCULAR THROMBOSIS

3 WEEKS

DUE TO

HYPERTENSIVE CARDIOVASCULAR DISEASE

10 YEARS

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

LAENNEC'S CIRRHOSIS

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that **X** (this hospital) attended the deceased from **Feb. 24, 1961** to **March 6, 1961** that **X** (we) last saw the deceased alive on **March 6, 1961**, and that death occurred at **1:30 P.M.** from the causes and on the date stated above.

22a. SIGNATURE

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS.

☒

22b. DATE SIGNED
3-6-61

22c. PHYSICIAN'S NAME (Type)

WILLIAM S. KISER

M.D.

VAH Baltimore, Md. - Ft Howard Division

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town or county)

(State)

Burial

3/10/61

BALTIMORE NATIONAL

BALTIMORE

MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Charles A. Rice Funeral Service Baltimore 30, Md

661 W Barre St

DATE **MAR 13 '61**

Arthur S. Kiser

60



1917



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2755

Item 14 Film G285 4/17/61 mb

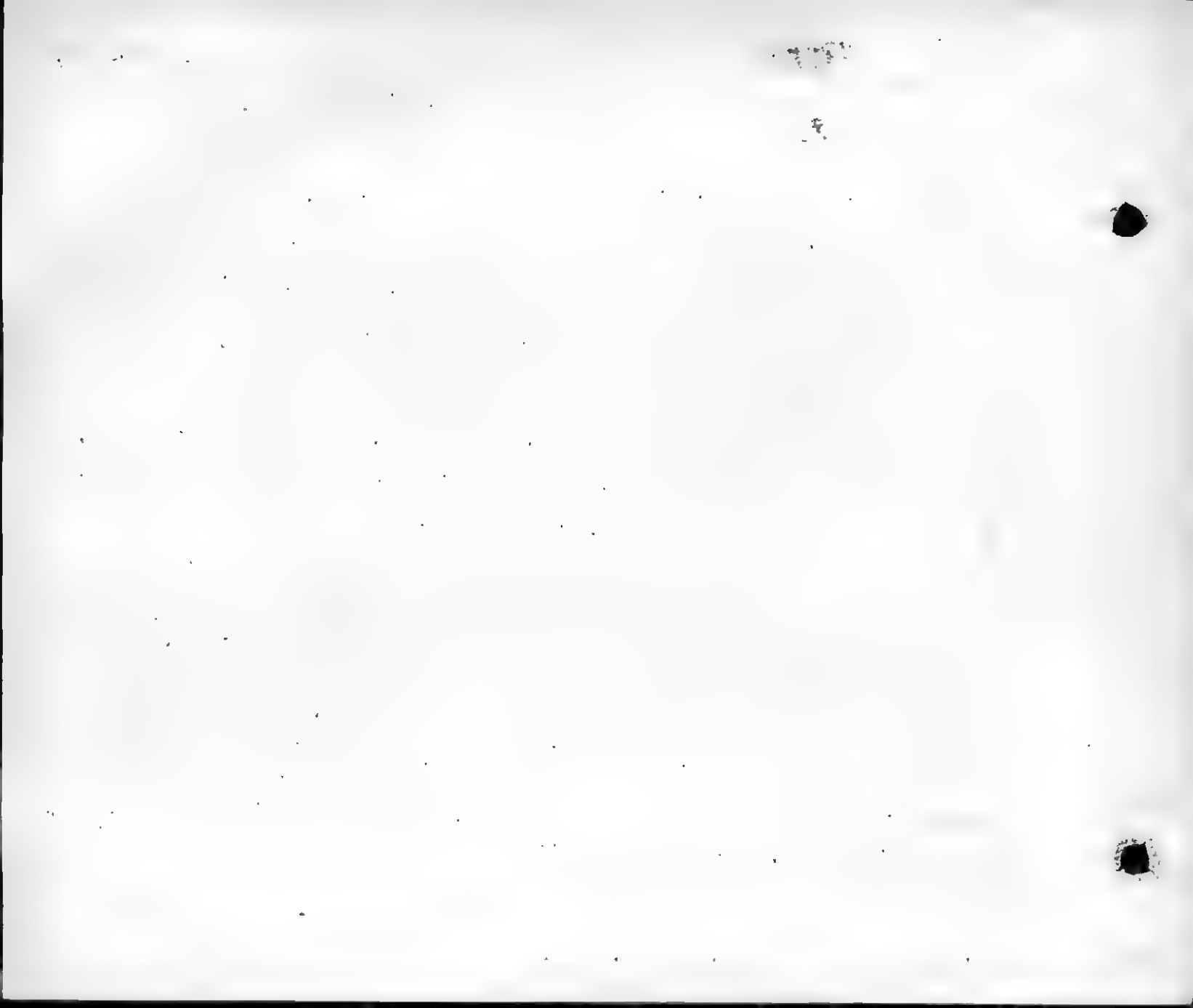
CERTIFICATE OF DEATH

Reg. Dist. No. 02736

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3205 Second Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle HESS Last HESS		4. DATE OF DEATH Month March Day 19 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1871
9. AGE (In years last birthday) 89		10. IF UNDER 1 YEAR Months 14 Days 24 Hours 19 Min. 39	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LITHOGRAPHER		10b. KIND OF BUSINESS OR INDUSTRY Retired 30 Yrs Philadelphia, Penna.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME August Hess		14. MOTHER'S MAIDEN NAME Barbara Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Mr. Walter Wm. Sonn-3205 Second Ave.		Address 3205 Second Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis, hemiplegia left 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 14 hours 1939	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 18, 1950 to March 19, 1961 , that I last saw the deceased alive on March 19, 1961 , and that death occurred at 11:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. J. Alessi		DATE SIGNED 3/20/61	
PHYSICIAN'S NAME (Type) E. J. Alessi; M.D.		ADDRESS (Street, city or town, state) 6217 Hartford Rd	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/22/61	22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. SANDER & SONS, INC. Balto., Md.		24a. REC'D BY REGISTRAR MAR 22 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



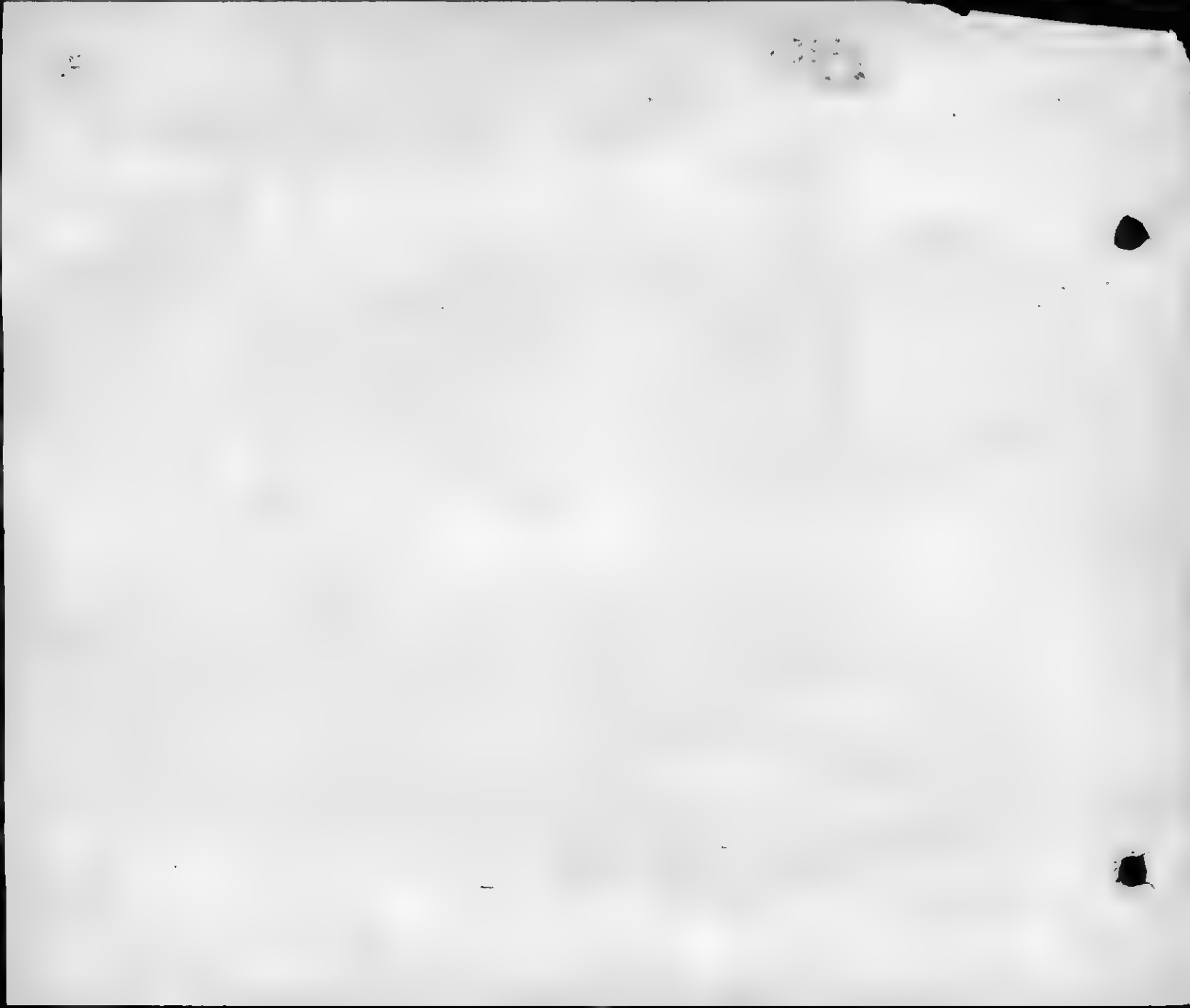
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2736
M
I
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02737

1. PLACE OF DEATH <i>Baltimore County</i> a. COUNTY <i>7829-Highpoint Rd</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>June 14</i> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give address)		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>X BALTIMORE</i> d. STREET ADDRESS <i>17829-Highpoint Rd</i>	
3. NAME OF DECEASED (Type or print) <i>Thomas</i> First Middle Last 4. DATE OF DEATH <i>MAR - 19 1961</i> Month Day Year		5. SEX <i>M</i> 6. COLOR OR RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>FEB - 21 - 1914</i> 9. AGE (in years last birthday) <i>47</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BENDIX</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>ROCHESTER, PA.</i> 11. BIRTH-PLACE (County & State, or foreign country) <i>USA</i> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Redman, Hogan</i> 14. MOTHER'S MAIDEN NAME <i>LUELLA - STEWART</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>187-011287</i> 16. SOCIAL SECURITY NO. <i>187-011287</i> 17. INFORMANT <i>BEATRICE JACOBS, 7829 Highpoint Rd</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma, right lung</i> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 19, to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above. 22a. SIGNATURE <i>James E. I. Hopkins</i> M.D. 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <i>JAMES E. I. HOPKINS</i> 22d. ADDRESS <i>205 W LANVALE ST BALTO MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> 23b. DATE THEREOF <i>3-22-61</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Doughterty Cem.</i> 23d. LOCATION (City, town or county) (State) <i>Rochester PA</i>		24. FUNERAL DIRECTOR'S SIGNATURE <i>LEONARD J. Ruck</i> ADDRESS <i>5305 Harford Rd</i> 25a. REC'D BY REGISTRAR <i>DATE MAR 21 '61</i> 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



1 FOR STATE HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY		Baltimore		a. STATE		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Catonsville		b. COUNTY			
c. LENGTH OF STAY IN TB		14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
SPRING GROVE STATE HOSPITAL				847 W. University Parkway			
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
Walter		Howard		Hollingshead			
4. DATE OF DEATH		Month		Day		Year	
March		12		19		61	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
male		white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept. 23, 1882	
9. AGE (In years last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
78 yrs.		salesman		Retired		Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
U. S. A.		Roger Hollingshead		Eugenia Barton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
no		212-07-5984		Mrs. Ellen K. Hollingshead		847 W. University Pk.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Interval between onset and death			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		331X		DUE TO		General Thrombosis (Central Accident)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO				arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
		X-ray of 3-2-61 revealed comminuted frac. of lateral end of left clavicle which pt. allegedly sustained in a fall at home.					
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (State)	
Hour a.m. p.m.		2-28 1961		home		Baltimore City	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER	
EXAMINER'S NAME (Type)		George M. Kieffer, M.D.		1010 Leaden		DATE SIGNED 3-13-61	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Burial		3-15-61		Mt. Olivet Cemetery		Baltimore, Maryland	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Wm. J. Lickner & Son		MAR 13 '61		Arthur L. Kneave			



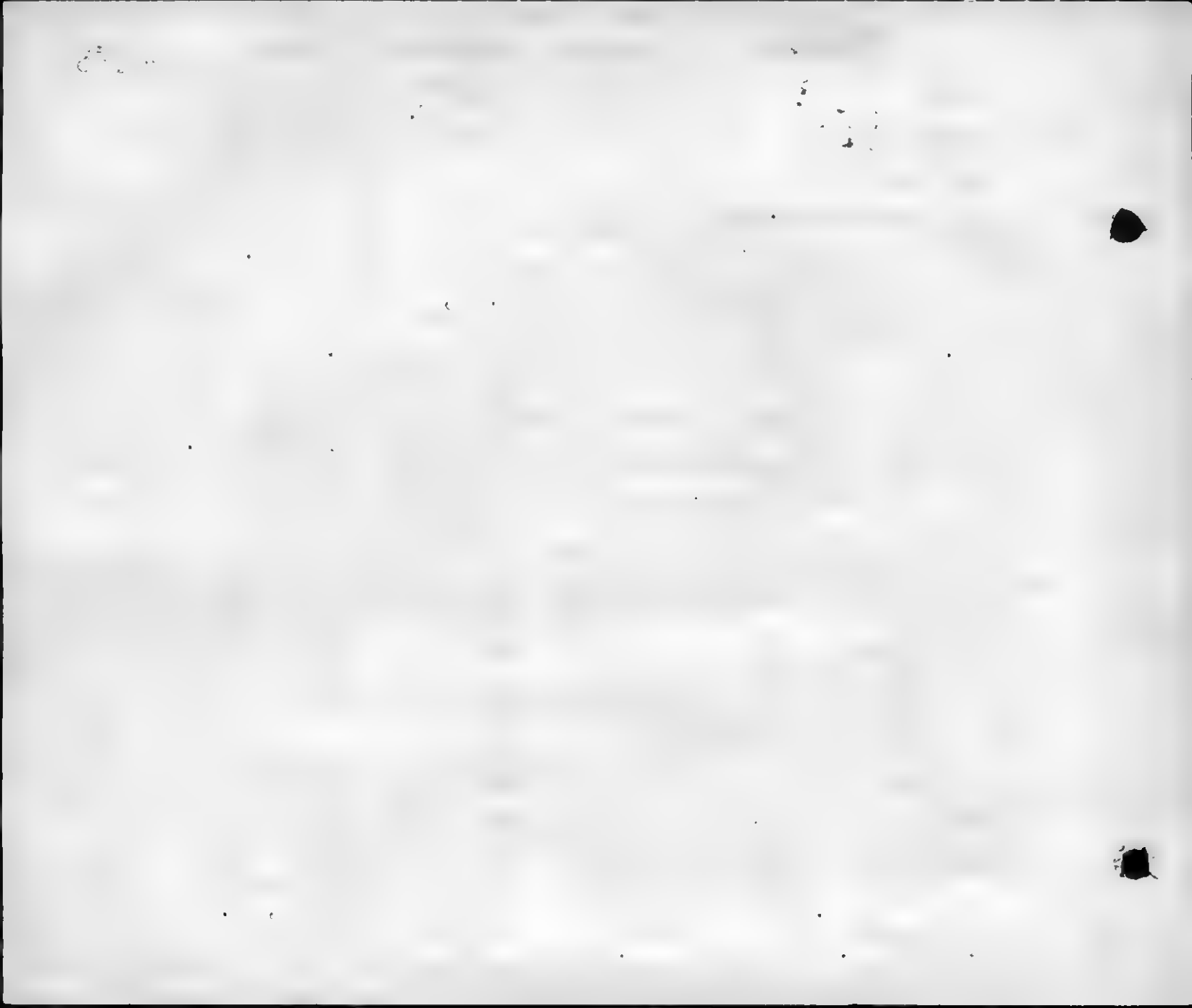
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2758 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02739**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11 Fairway Rd.				d. STREET ADDRESS 11 Fairway Road			
3. NAME OF DECEASED (Type or print) First Alfred H Middle HUDNET Last HUDNET				4. DATE OF DEATH Month Mar. Day 15 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH Dec. 28, 1907		9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Surveyor		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Baltimore, Md.			
13. FATHER'S NAME Augustus R Hudnut				14. MOTHER'S MAIDEN NAME Florence W. Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 		17. INFORMANT Address Samuel S Hudnut 329 Taylor Ave. 21			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1716X Suicide - gunshot DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hour							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Pl. Shot SELF in Left chest with 12 gauge shotgun							
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 			
20f. (City or town) 		(County) 		(State) 			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE Jack Collins				DATE SIGNED 3-15-61			
EXAMINER'S NAME (Type) JACK COLLINS				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 18, 1961		22c. NAME OF CEMETERY OR CREMATORY Parkwood			
22d. LOCATION (City, town, or county) Baltimore, Md.		(State) 					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Cook, Inc. 1217 St. Paul St.				24a. REC'D BY REGISTRAR MAR 21 '61			
				24b. REGISTRAR'S SIGNATURE Arthur L. House			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

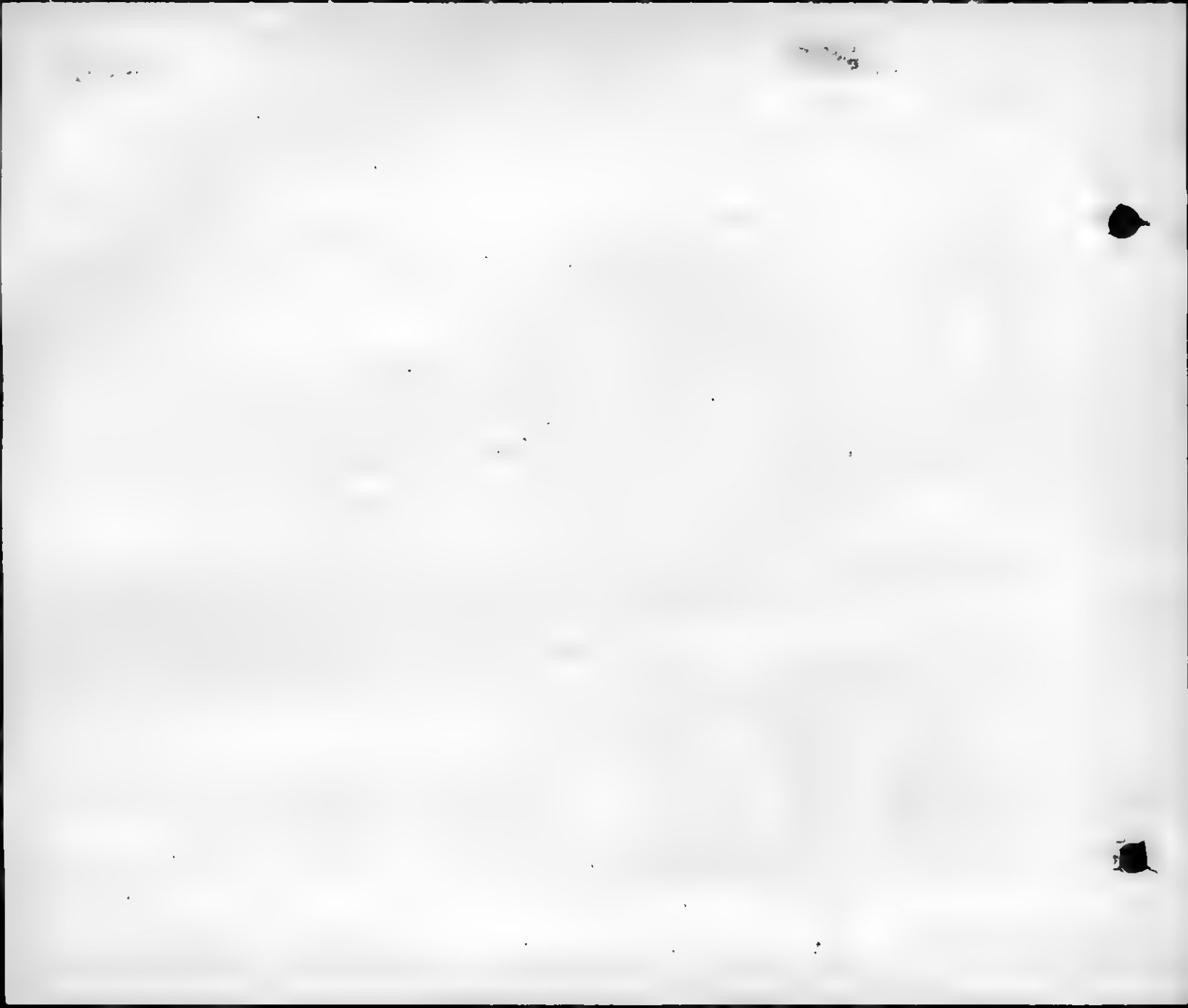


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2759
CERTIFICATE OF DEATH
02740

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admitt on) a. STATE <u>Maryland</u> b. COUNTY <u>Sevier</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>EUGENE HUNDERTMARK</u>		4. DATE OF DEATH <u>March 4 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27-1950</u>
9. AGE (In years last birthday) <u>30</u> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hundertmark</u>		14. MOTHER'S MAIDEN NAME <u>Martha Bonney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>no</u>	
17. INFORMANT <u>Joe G. Hundertmark Reisterstown Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4.0.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>none</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>none</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-16-54</u> 19 <u>54</u> , to <u>3-4</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3-2-61</u> 19 <u>61</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>D. D. Caples</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>D. D. CAPLES, M.D.</u>		22d. ADDRESS <u>6 Hanover Rd, Reisterstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-7-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wilt Farm</u>		23d. LOCATION (City, town, or county) (State) <u>Reisterstown Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin E. Repton</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 9 '61</u>	
ADDRESS <u>Hampstead Tld</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

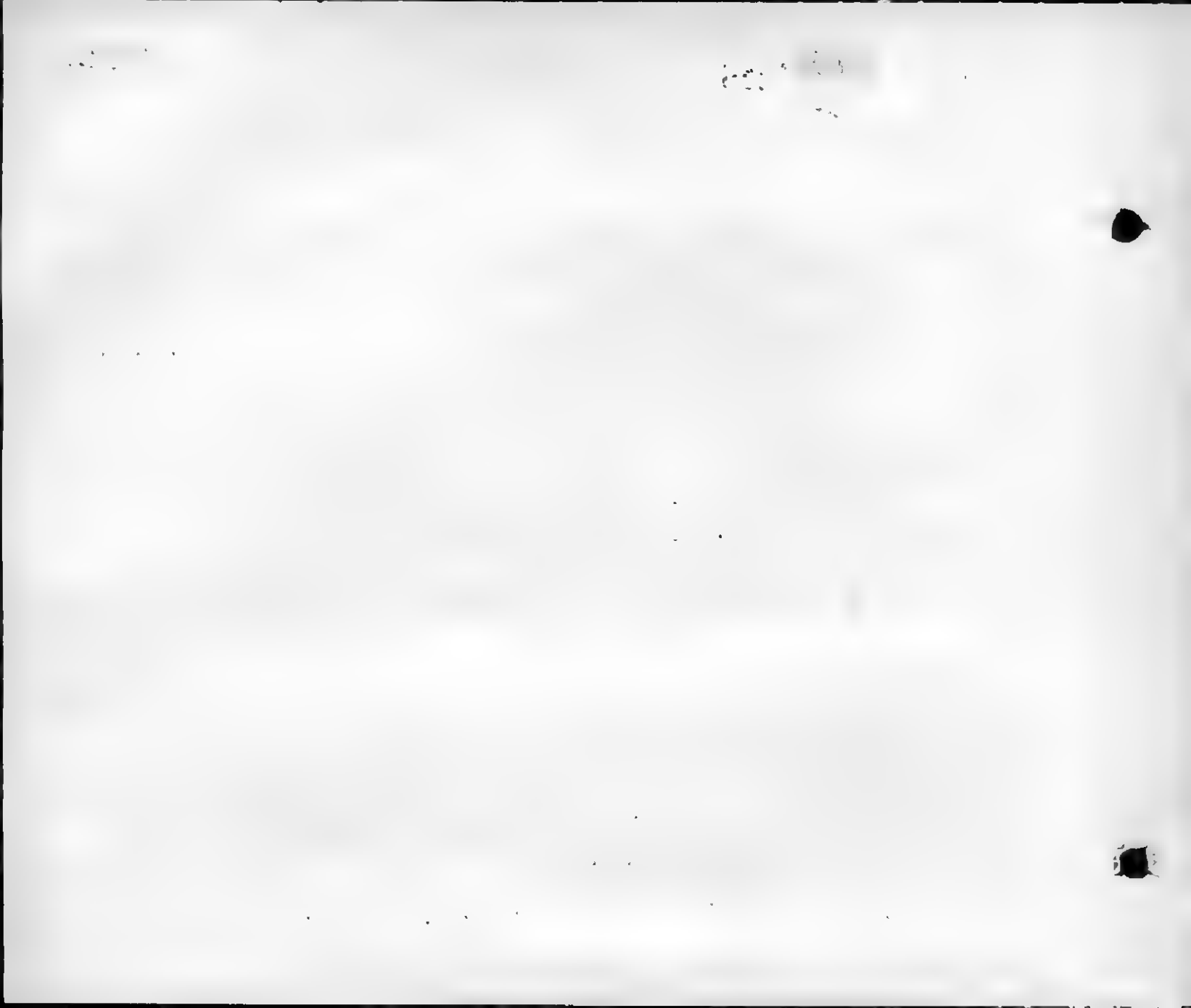


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2760

02742

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 48yr8mth14dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lottie Middle Hyder Last Hyder				4. DATE OF DEATH Month March Day 22 Year 19 61			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1884?	9. AGE (In years last birthday) 76 yrs	IF UNDER 1 YEAR Months 76 Days 76	IF UNDER 24 HRS Hours 76 Min 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 4000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 1, 19 57 to March 22, 1961 , that (I) (we) last saw the deceased alive on March 2, 19 61 , and that death occurred at 5:30 P. M. from the causes and on the date stated above							
22a. SIGNATURE Stella Wachslar		M.D.	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 3-23-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 3/25/61	23c. NAME OF CEMETERY OR CREMATORY Catharose		23d. LOCATION (City, town, or county) (State) 4300 Lee Frederick			
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Zahay		ADDRESS 1318 Eigh		25a. REC'D BY REGISTRAR DATE MAR 27 '61	25b. REGISTRAR'S SIGNATURE William S. Kenna		



TO REGISTER OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2761

02743

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>4yr 5mth ldy</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>28 South Benkert Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>J.</u> Last <u>Imbrogulio</u>				4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 24, 1899</u>	
9. AGE (In years last birthday) <u>61</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fuel oil distributor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>fuel oil bus.</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>							
13. FATHER'S NAME <u>Samuel Imbrogulio</u>				14. MOTHER'S MAIDEN NAME <u>Concetti Magio</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W. W. I.</u>		16. SOCIAL SECURITY NO. <u>215-03-0403</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 16, 1960</u> to <u>March 7, 1961</u> that (I) (we) last saw the deceased alive on <u>March 7, 1961</u> and that death occurred at <u>3:20</u> P. M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Stella Wachslar, M. D.</u>				22b. DATE SIGNED <u>3-7-61</u>		22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>	
22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-10-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schwab</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 8 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2762

CERTIFICATE OF DEATH

Items 13 & 14 Film 6282 3/16/61 mh

02744

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>17</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3040 Fourth Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Lawrence Jackson</u>		4. DATE OF DEATH Month <u>3</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>male</u>		6. AGE (In years last birthday) <u>64</u> yrs.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-2-1896</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>216057642</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Coronary Thrombosis</u> <u>Arteriosclerotic Cardiovascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemiplegia of Old Cerebrovascular Thrombosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of item 18.) <u>Jan 1958 to Nov 1961</u>	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Jan 1958 to Nov 1961</u>		20f. (City or town, County, State) <u>Carney Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1958 to Nov 1961</u> , the (I) (we) last saw the deceased alive on <u>3/2/1961</u> , and that death occurred at <u>9:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank T. Kasik</u>		22b. DATE SIGNED <u>Mar 13 '61</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK T KASIK</u>		22d. ADDRESS <u>9005 HARFORD RD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>3/13/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. PK</u>		23d. LOCATION (City, town or county) (State) <u>BALTO. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>5305 Harford Rd.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>		25c. DATE <u>MAR 13 '61</u>	

I



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2763 CERTIFICATE OF DEATH 02745

1 PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arco Arco</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Arco Arco</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>40 Left Wing Drive</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>FLORENCE</i> First Middle Last <i>L. JACOB</i>		4 DATE OF DEATH <i>Mar. 27</i> Month Day Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 10-1890</i>
9. AGE (In years last birthday) <i>70</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>August Garber</i>		14. MOTHER'S MAIDEN NAME <i>Subrina Fields</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Husband</i> Address <i>Same as above</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bronchial Pneumonia</i> <i>170X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Carcinomatosis</i> DUE TO (c) <i>Carcinoma of Breast</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>2 yrs</i> <i>5 yrs</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>Jan 1</i> 1961 to <i>March 27</i> 1961, that (I) (we) last saw the deceased alive on <i>March 27</i> 1961, and that death occurred at <i>9 P</i> M, from the causes and on the date stated above.			
22a SIGNATURE <i>JMB Armgardner</i> M.D.		22b DATE SIGNED <i>3/29/61</i>	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS <i>Balto 6 Md</i>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF <i>3-30-1961</i>	
23c NAME OF CEMETERY OR CREMATORY <i>Balto Natl Cemetery</i>		23d LOCATION (City, town, or county) (State) <i>Dickinson Md</i>	
24 FUNERAL DIRECTOR'S SIGNATURE <i>John G. Connelly</i> ADDRESS <i>418 Eastern Blvd 21, Md</i>		25 REC'D BY REGISTRAR <i>PR 3 '61</i> DATE	
25 REGISTRAR'S SIGNATURE <i>William S. Kraus</i>			





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2764 CERTIFICATE OF DEATH

02748

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>50 Days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 17</u>		d. STREET ADDRESS <u>1912 McKean Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CLIFTON</u>		First		Middle		Last <u>JAMES</u>		4. DATE OF DEATH Month <u>March</u>		Day <u>4</u>		Year <u>19 61</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 31, 1893</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>67</u>		Days <u>19</u>		Hours <u>61</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brakeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mathews Co., Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>William James</u>		14. MOTHER'S MAIDEN NAME <u>Mary Smith</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>705-07-7915</u>		17. INFORMANT <u>Clinical Records, VAH, Baltimore 18, Md. Ft. Howard Division</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA OF PENIS WITH METASTASIS</u> 179.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UNKNOWN</u>																	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (X) (this hospital) attended the deceased from <u>January 13, 19 61</u> to <u>March 4, 19 61</u> , that (X) (we) last saw the deceased alive on <u>March 4, 19 61</u> , and that death occurred at <u>5:05</u> M., from the causes and on the date stated above.																	
22a. SIGNATURE <u>Thomas F. Crahan</u> M.D.																	
22b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>																	
22c. ADDRESS <u>VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION</u>																	
22d. DATE <u>3/6/61</u>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3, 6, 61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore 28, Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>McCrinmon Funeral Home</u> ADDRESS <u>2302 W. North Avenue Baltimore 16, Maryland</u>																	
25a. REC'D BY REGISTRAR DATE <u>MAR 6 '61</u>																	
25b. REGISTRAR'S SIGNATURE <u>Wm. E. Thomas</u>																	

MEDICAL CERTIFICATION

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1881

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2765

CERTIFICATE OF DEATH

Reg. Dist. No. 02747

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 6</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1818 Weyburn Rd</u>		d. STREET ADDRESS <u>3205 BATHURIA AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>ESTHER ESTELLA JANSEN</u>		4. DATE OF DEATH <u>MARCH 5 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 5 1907</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BALTO. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM MILLER</u>		14. MOTHER'S MAIDEN NAME <u>LOUIA WEITZEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>ALFRED H. JANSSEN</u>		Address <u>3205 BATHURIA AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO <u>153, 2</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA, GENERALIZED</u> (c) <u>CARCINOMA, SIGMOID COLON</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 WK.</u> <u>5 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>AUG. 1956</u> to <u>MARCH 1961</u> , that I last saw the deceased alive on <u>MAR. 2 1961</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 W. MADISON ST. BALTO. 1 MD.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>James A. O'Hare</u> M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-8-1961</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lenard Ruck</u> ADDRESS <u>5305 Bayford</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hanes</u> DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2766

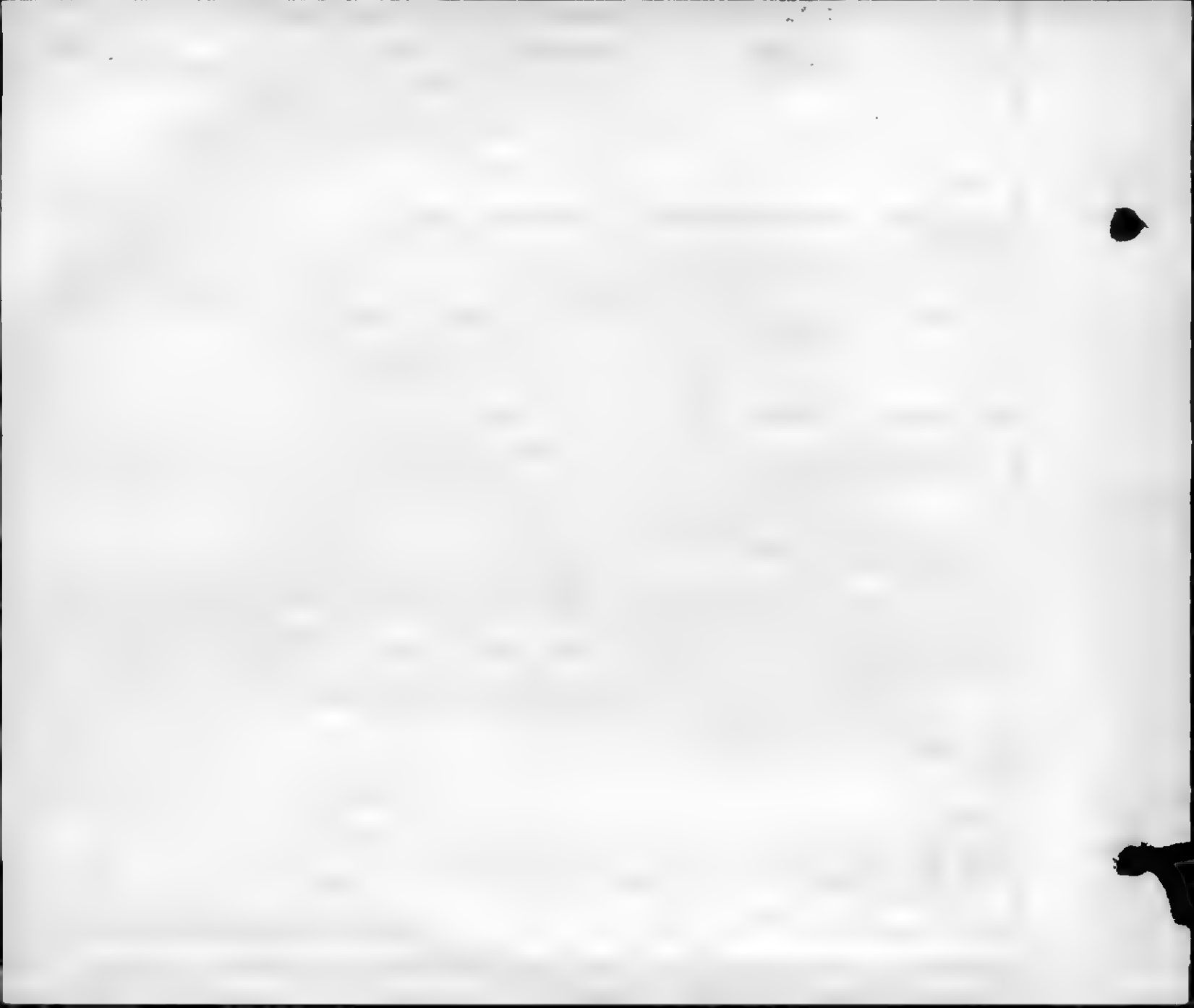
CERTIFICATE OF DEATH

Reg. Dist. No. 02748

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keisterstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b <u>82 years</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wesley</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>(W)</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1878</u>
9. AGE (In years last birthday) <u>82 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer, general</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Howard Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Hanne Wallace</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-36-307</u>	
17. INFORMANT <u>Wesley Johnson</u> Address <u>257 14th St Keisterstown</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Vascular Cerebral Nec</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HASCD</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>30 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>60</u> , to <u>Mar 1</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb 1</u> , 19 <u>61</u> , and that death occurred at <u>6:17</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Wesley Johnson</u> M.D.		ADDRESS (Street, city or town, state) <u>14th St Keisterstown</u>	
PHYSICIAN'S NAME (Type) <u>John Wesley Johnson</u>		DATE SIGNED <u>3/1/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>	22b. DATE THEREOF <u>March 4</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Keisterstown</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson</u>		24a. REC'D BY REGISTRAR <u>1</u>	24b. REGISTRAR'S SIGNATURE <u>1</u>

MEDICAL CERTIFICATION

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

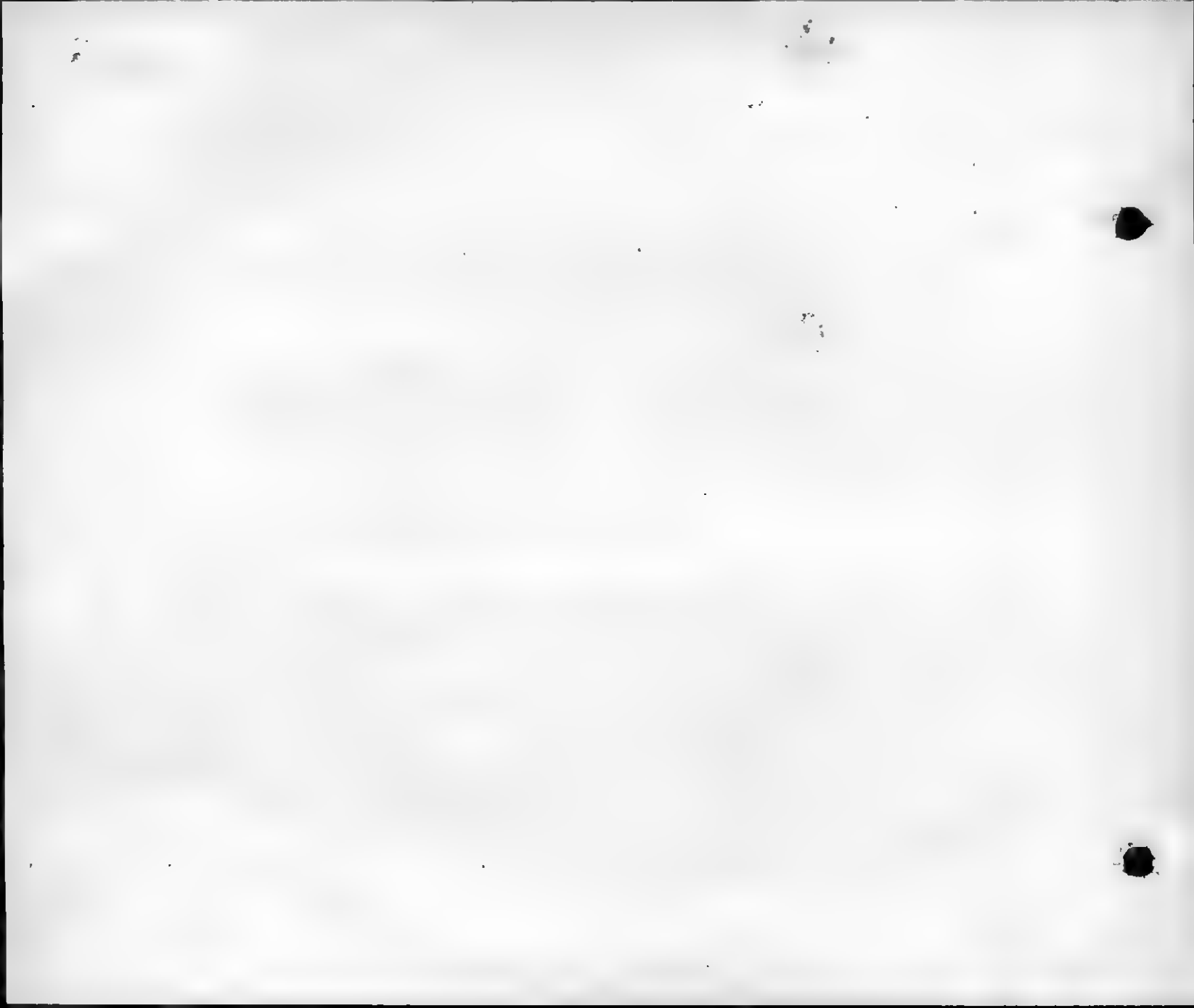
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

<div style="text-align: center;"> 2767 <div style="display: inline-block; text-align: right;"> 02744 </div> </div> <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD b. COUNTY Prince George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland			c. LENGTH OF STAY IN 1b 16mo 18days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland 16X-2				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital					d. STREET ADDRESS 4 Summers Rd			• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lulu Middle Marie Last Johnson					4. DATE OF DEATH Month 3 Day 6 Year 1961				
5. SEX W F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/2/1977		9. AGE (In years last birthday) 83 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John A. Ireland					14. MOTHER'S MAIDEN NAME Martha Phipps				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism XXXX DUE TO (b) Thrombosis of Iliac Vein Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. DUE TO (c) _____									INTERVAL BETWEEN ONSET AND DEATH 3 days ?
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiac Disease with Failure									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/16 1959 to 3/6 1961 , that (I) (we) last saw the deceased alive on 3/6 1961 , and that death occurred at 8 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Wm. Newcomer					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/6/61		
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent					22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/8/1961		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City, town, or county) (State) Fort Belvoir, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Glenn Lutz					ADDRESS 5209 York Road.		25a. REC'D BY REGISTRAR MAR 10 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kline

I

2



CERTIFICATE OF DEATH

Reg. Dist. No.

02750

2768

1 PLACE OF DEATH o. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale</u> d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1024 Chesaco Ave.</u>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural - Rosedale</u> d STREET ADDRESS <u>11024 Chesaco Ave</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Mary Anna Karl</u>		4. DATE OF DEATH Month Day Year <u>March 11 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 20, 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Ambrose Hessler</u>		14. MOTHER'S MAIDEN NAME <u>Anna Hasenel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Edward J. Karl 1024 Chesaco Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Arteriosclerosis; metast. brain tumor</u> DUE TO (c) <u>Carcinoma of the intest.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>34 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1958</u> , 19, to <u>3-11-</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>3-10-</u> , 19 <u>61</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr John Geldrich</u> M.D.		ADDRESS (Street, city or town, state) <u>8019 Philadelphia Rd. Philadelphia</u> DATE SIGNED <u>March 14, 1961</u>	
PHYSICIAN'S NAME (Type) <u>John Geldrich M.D.</u>		March 11, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-14-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Jesus Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Crouch</u> ADDRESS <u>1211 Chesaco Ave. Zone 6.</u>		24a. REC'D BY REGISTRAR <u>MAR 14 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Philip E. Crouch</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2769 Item 22b, Form G-24 4/6/61 iwk
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No. 02751

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home		d. STREET ADDRESS 30 York Road	
3. NAME OF DECEASED (Type or print) First EDITH Middle J. KEENE Last		4. DATE OF DEATH March 31, 1961 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/5/78
9. AGE (In years last birthday) yrs 82		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elias Jones		14. MOTHER'S MAIDEN NAME Mary Nichols	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-26-2341	
17. INFORMANT Records-Towson Conval. Home-Towson, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS (c)		INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/18/56 , 19____, to 3/31/61 , 19____, that I last saw the deceased alive on 3/24/61 , 19____, and that death occurred at 12:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE T. C. Siwinski		ADDRESS (Street, city or town, state) 206 W. Pennsylvania Ave.	
PHYSICIAN'S NAME (Type) Thaddeus C. Siwinski		DATE SIGNED 3/31/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 2, 1961	
22c. NAME OF CEMETERY OR CREMATORY Old Trinity		22d. LOCATION (City, town, or county) (State) Church Creek, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc.		24a. REC'D BY REGISTRAR DATE APR 3 '61	
24b. REGISTRAR'S SIGNATURE C. J. J. J.			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

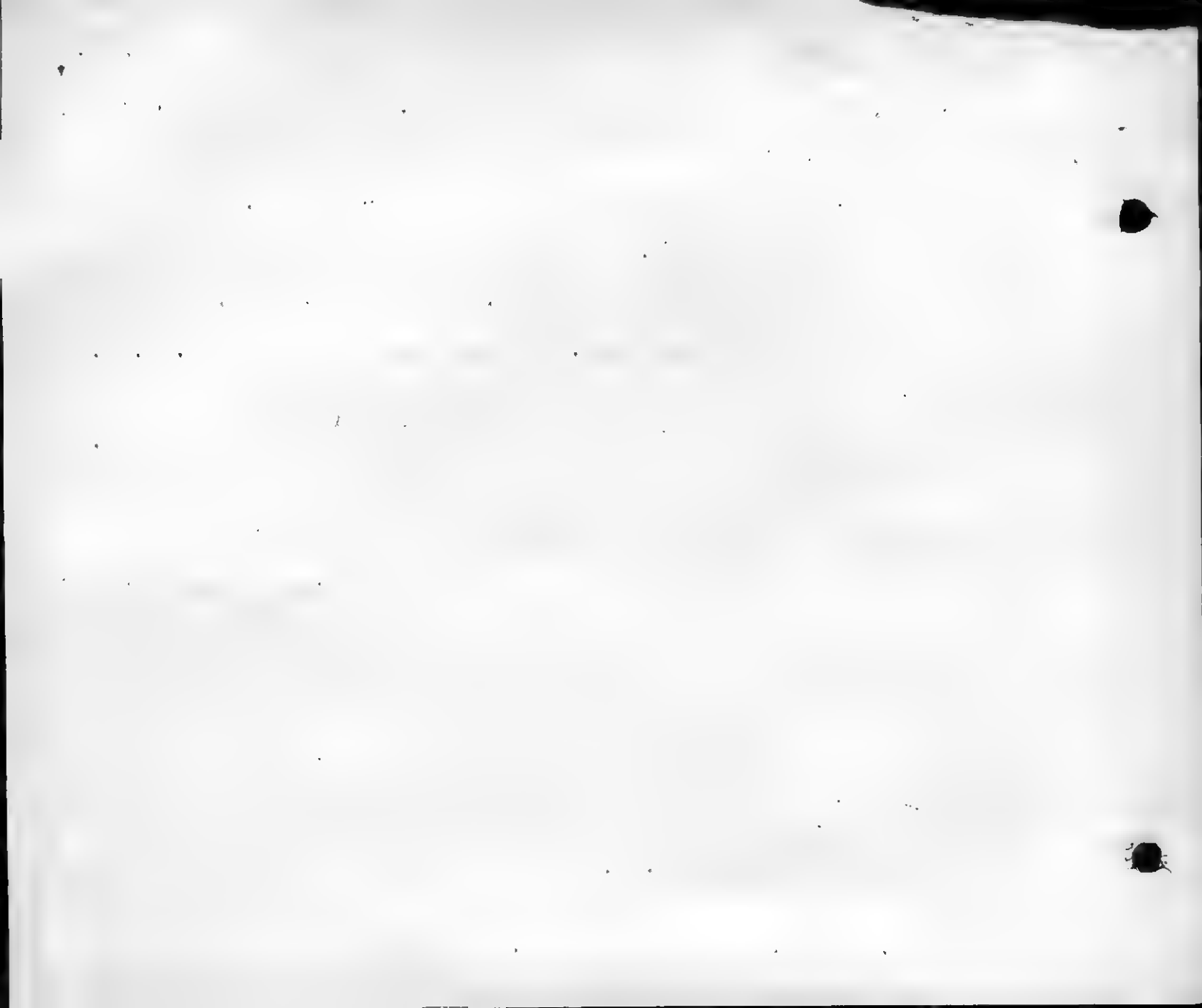
2770

02752

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4406 Highview Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle W. Last Kluth		4. DATE OF DEATH Month March Day 22 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1883
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		10b. KIND OF BUSINESS OR INDUSTRY Grief Bros.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 191098563	
17. INFORMANT (daughter) Charlotte Miller		Address 4406 Highview Ave. #29	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Cerebro-Vascular Accident DUE TO (c) Arteriosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1958 to March 22, 1961 , that (I) (we) last saw the deceased alive on March 22, 1961 , and that death occurred on March 22, 1961 from the causes and on the date stated above.			
22a. SIGNATURE James Frederick		22b. DATE SIGNED 5/23/61	
22c. PHYSICIAN'S NAME (Type) John H. Hubbert M. D.		22d. ADDRESS 1305 Francis Avenue #27	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/25/61	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR MAR 27 '61	
ADDRESS 4107 Wilkens Ave.		25b. REGISTRAR'S SIGNATURE G. E. K...	

(M)

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

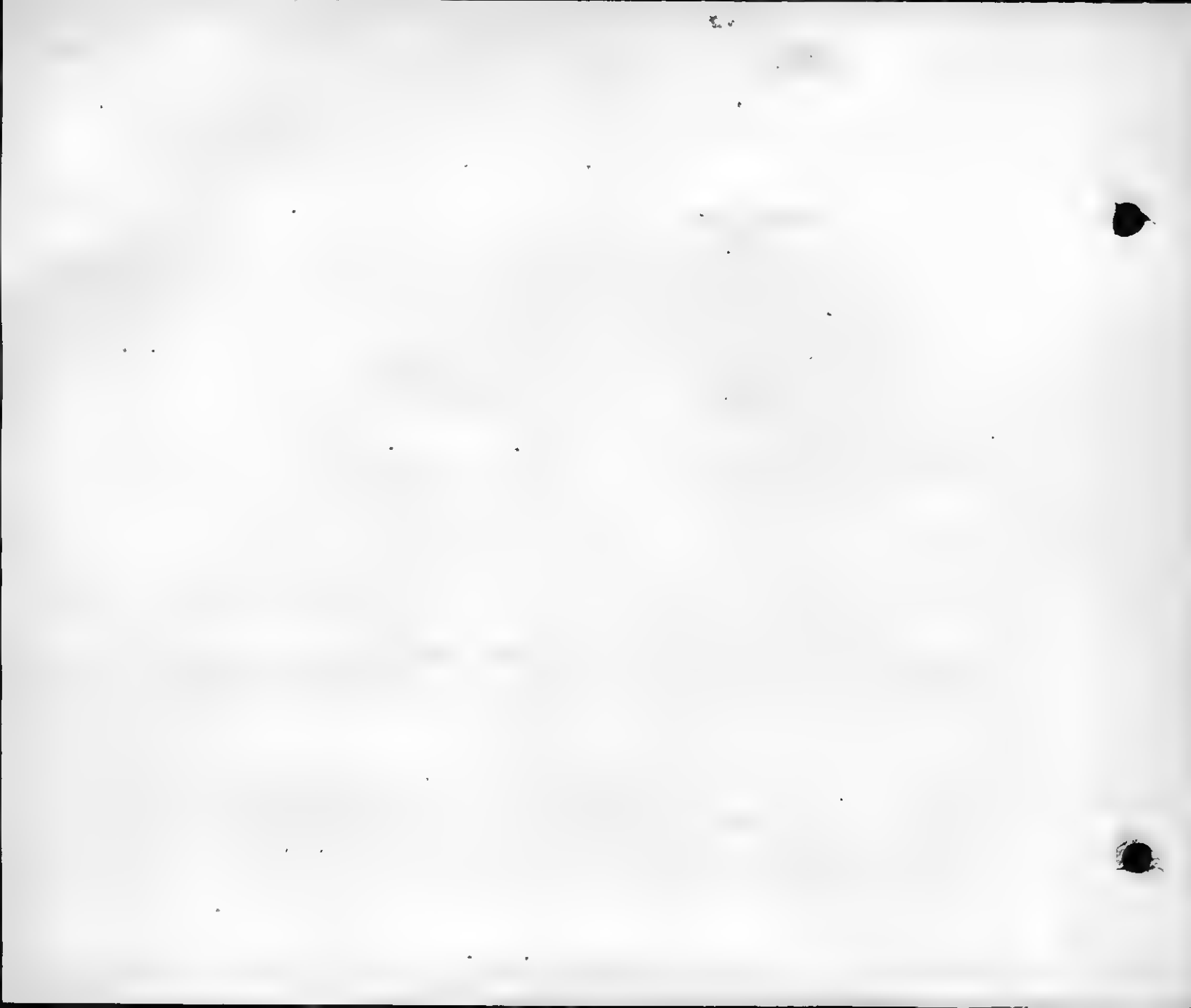
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2771

CERTIFICATE OF DEATH

02753

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton				c. LENGTH OF STAY IN 1b 30 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Monkton Rd.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton			
f. STREET ADDRESS Monkton Rd.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle KUPISCH Last				4. DATE OF DEATH Month 3 Day 7 Year 61			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-7-1903	
9. AGE (In years lost birthday) 58 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter helper				10b. KIND OF BUSINESS OR INDUSTRY railroad		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Gottlieb Kupisch				14. MOTHER'S MAIDEN NAME Clara Kock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Helen H. Kupisch				Address above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-Sclerotic Cardio-Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH 1 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 1955 to March 7, 1961 , that (I) (we) lost saw the deceased alive on March 6, 1961 , and that death occurred at 7 a. M. from the causes and on the date stated above.							
22a. SIGNATURE M. C. Porter				22b. DATE SIGNED 3/7/61			
22c. PHYSICIAN'S NAME (Type) M. C. Porterfield				22d. ADDRESS Hampstead, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3-10-61		23c. NAME OF CEMETERY OR CREMATORY Cedar Grove	
23d. LOCATION (City, town, or county) (State) Parkton, Md.				23e. REC'D BY REGISTRAR DATE MAR 13 '61			
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.				25b. REGISTRAR'S SIGNATURE Arthur S. Hanes			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2772 CERTIFICATE OF DEATH

02754

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN 1b <u>1 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Train. School</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO. 22, Md.</u> d. STREET ADDRESS <u>11917 EASTFIELD Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES JOHN LASER</u>		4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>11-10-30</u>	9. AGE (in years, last birthday) <u>30</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTO., Md.</u>	
13. FATHER'S NAME <u>Frederick Laser</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Mary Laser-NEE (Losencky)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Frederick Laser (Brother)</u> Address <u>BALTO., 22, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hemiparesis</u> DUE TO (b) <u>chronic hypertension</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, Hemiparesis, etc.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>8/3</u> 19 <u>60</u> to <u>3/5</u> 19 <u>61</u> ; that (I) (we) last saw the deceased alive on <u>3/5</u> 19 <u>61</u> , and that death occurred at <u>12:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James J. Gule</u>		22b. DATE SIGNED <u>3/5/1961</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/7/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town or county) <u>A. A. Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Frankowski</u>		25a. REC'D BY REGISTRAR <u>AMAR 7 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

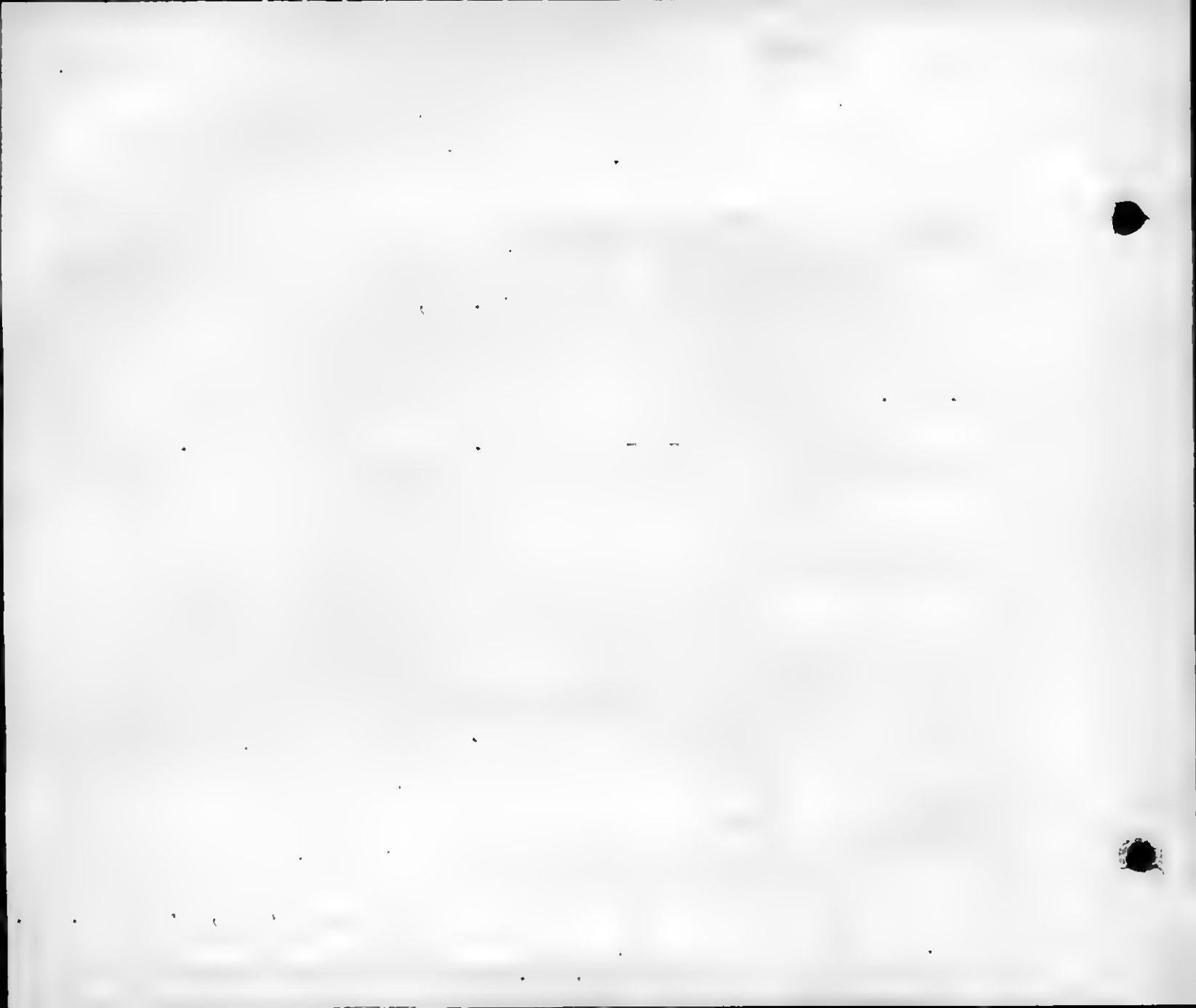
VR A15 (4)
15M 9/59

2773

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02755

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY 2			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middleborough				c. LENGTH OF STAY IN 1b 1 yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 202 Oak Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Edna Mary McCloud Latone				4. DATE OF DEATH March 24 1961			
5. SEX Female				6. COLOR OR RACE White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Oct. 28, 1904			
9. AGE (In years last birthday) 56 yrs				10. IF UNDER 1 YEAR Months Days Hours Min			
11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John M. McCloud				14. MOTHER'S MAIDEN NAME Hettie McDonald			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 186-20-7464			
17. INFORMANT Earl L. Morris Address 202 Oak Ave.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of uterus DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Nov. 1960 to 24 March 1961 , that (I) (we) last saw the deceased alive on 9 Feb. 1961 , and that death occurred at 9:30 AM , from the causes and on the date stated above. 22a. SIGNATURE Morris Rainess M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 3-24-61 22c. PHYSICIAN'S NAME (Type) Morris Rainess 22d. ADDRESS 1105 OLD EASTERN AVE. FOSSEX, MD.				INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3-26-61			
23c. NAME OF CEMETERY OR CREMATORY Rosemont				23d. LOCATION (City, town, or county) (State) Center Township, Green Co. Pa.			
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sosn, Inc. ADDRESS 1900 Eutaw Place Baltimore 17, Md.				25a. REC'D BY REGISTRAR DATE MAR 27 '61 25b. REGISTRAR'S SIGNATURE Catharine S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2774 Item 2 Film G283 3/24/61 jwk											
02756											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if not in U.S. residence before admission) a. STATE Maryland				b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN MD 14 Days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie Baltimore 16, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 1401 Poplar Grove St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HORACE				f. DATE OF DEATH March 15 19 61				g. DATE OF DEATH March 15 19 61			
5. SEX Male				6. COLOR OR RACE Negro				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Furniture Store				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			
13. FATHER'S NAME Jim Lee				14. MOTHER'S MAIDEN NAME Fannie MN: Unknown				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. XXXX				17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PYELONEPHRITIS, CHRONIC WITH UREMIA 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) HYPERTENSIVE CARDIOVASCULAR DISEASE WITH CONGESTIVE FAILURE (a), stating the underlying cause last. (c) XXXX				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SEPTICEMIA AND BRONCHOPNEUMONIA				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that (X) (this hospital) attended the deceased from March 1, 1961, to March 15, 1961, that (X) (we) last saw the deceased alive on March 15, 1961, and that death occurred at p.m. from the causes and on the date stated above.											
22a. SIGNATURE Thomas F. Crahan				22b. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.				22c. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION			
22d. DATE SIGNED 3/17/61				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3-20-1961				23c. NAME OF CEMETERY OR CREMATORY Baltimore National			
23d. LOCATION (City, town or county) Baltimore				23e. (State) Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips				24b. ADDRESS 1808 N. Monroe St. Baltimore 17, Md.				25a. REC'D BY REGISTRAR MAR 21 '61			
25b. REGISTRAR'S SIGNATURE Charles E. Kraus											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

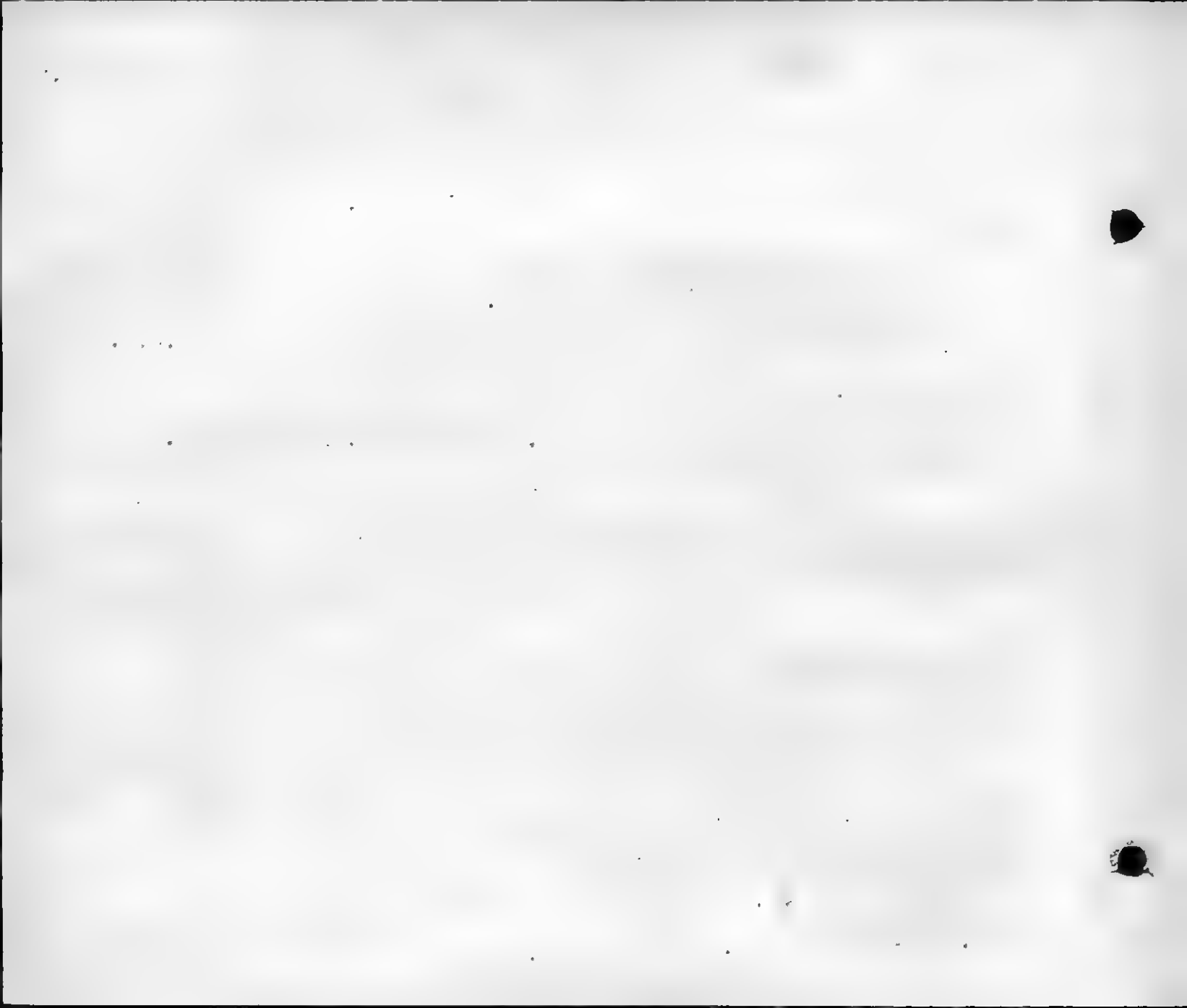
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2775

CERTIFICATE OF DEATH

Reg. Dist. No. 02757

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armcast Nursing Home		d. STREET ADDRESS 5207 York Rd.	
3. NAME OF DECEASED (Type or print) PEARL E. LEISTER First Middle Last		4. DATE OF DEATH Month March Day 5 Year 1961	
5. SEX F	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1883
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore R. Grove		14. MOTHER'S MAIDEN NAME Anna E. Fletcher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Luella Stees, 5207 York Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 wk. 9 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 26 , 19 60 , to Mar. 5 , 19 61 , that I last saw the deceased alive on Mar. 4 , 19 61 , and that death occurred at 9:55 A . M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Carl F. Benson, MD.		ADDRESS (Street, city or town, state) 5111 York Rd. Balto.	
PHYSICIAN'S NAME (Type) Carl F. Benson, MD.		DATE SIGNED Mar. 5, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF Mar. 8, '61	22c. NAME OF CEMETERY OR CREMATORY Green Lawn Memorial Park	22d. LOCATION (City, town, or county) (State) Barberton, Ohio
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc. 1050 York Rd.		24. REC'D BY REGISTRAR DATE MAR 7 '61	
		24b. REGISTRAR'S SIGNATURE Arthur E. Hanks	



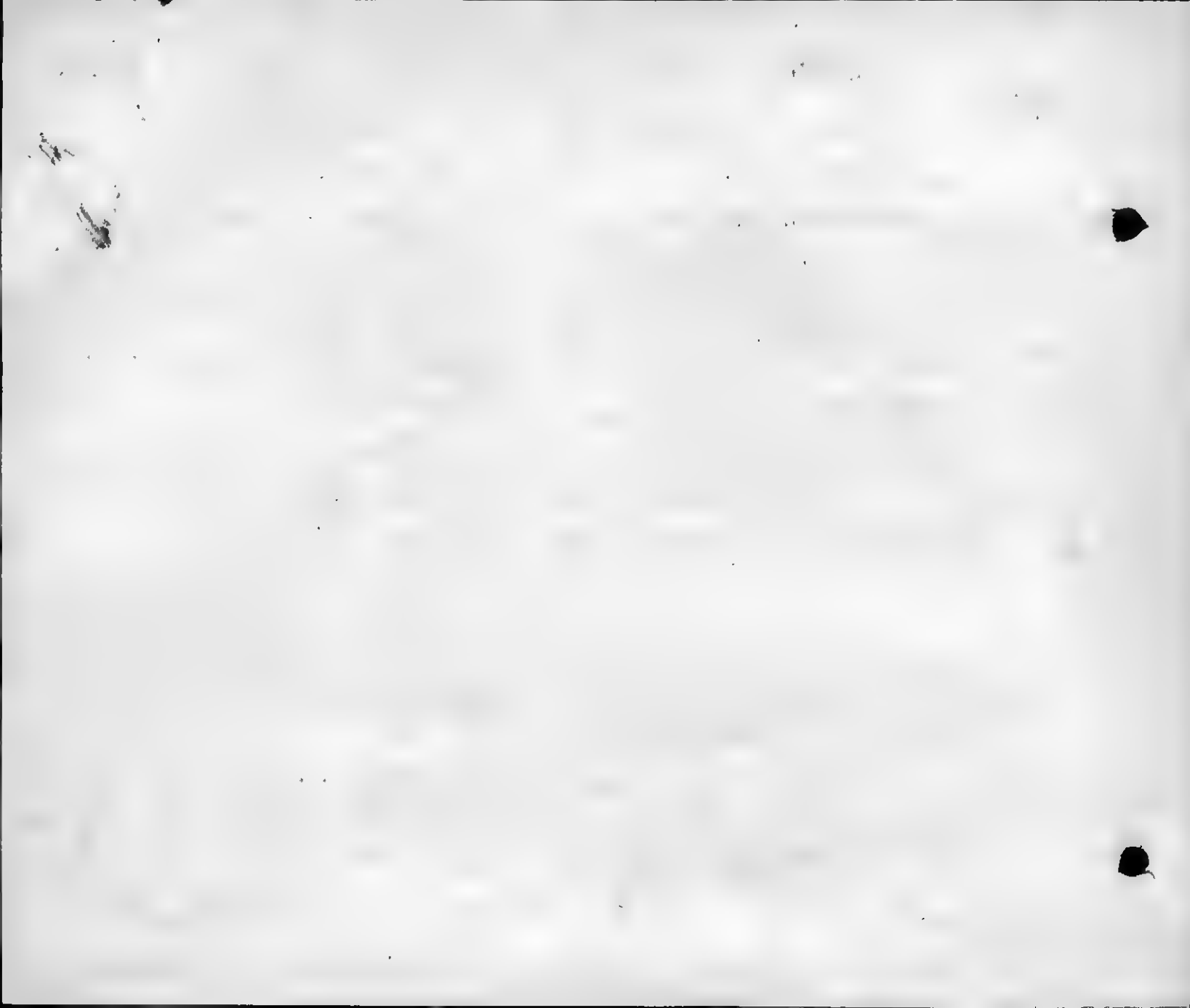
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2776
CERTIFICATE OF DEATH

02758

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Md.		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood St. Tr. School		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 15	
3. NAME OF DECEASED (Type or print) Cerald Myron Levin		f. STREET ADDRESS 3907 Dolfield Avenue	
4. DATE OF DEATH Month 3 Day 15 Year 19 61		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/31/43	
9. AGE (In years last birthday) 17 yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS., Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Levin		14. MOTHER'S MAIDEN NAME Rebecca Bilane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ---	
17. INFORMATION Rosewood Records, Owings Mills, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute and chronic broncho-pneumonia complicating mongolism CONDITIONS, (b) 471X gave rise to immediate cause (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). ---			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at 10:05 a.m. from the causes and on the date stated above.			
22a. SIGNATURE John W. Rieckert		22b. DATE SIGNED 3-15-61	
22c. PHYSICIAN'S NAME (Type or print) John W. Rieckert		22d. ADDRESS 4307 Mainfield Ave, Balto 14	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-17-61	
23c. NAME OF CEMETERY OR CREMATORY United Hebrew		23d. LOCATION (City, town or county) (State) Balto Md	
24. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Inc. 2100 E. ...		25a. REC'D BY REGISTRAR DATE MAR 17 '61	
25b. REGISTRAR'S SIGNATURE ...			

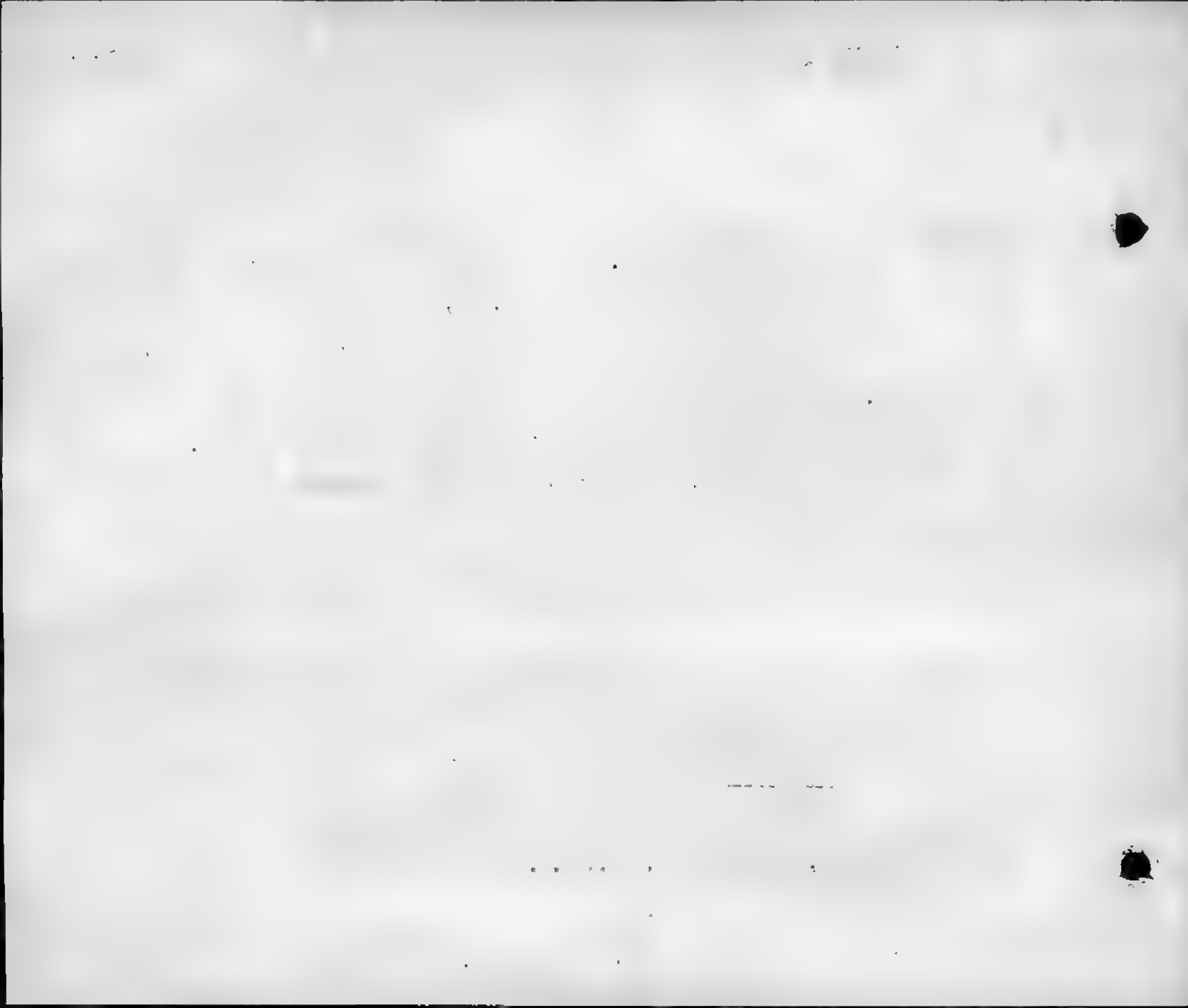


1 3
FOR STATE HEALTH DEPT.

TO DELIVER BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2777 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02759									
Item 8 Film G282 3/15/61 mh									
1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Catonsville		c. LENGTH OF STAY IN		b. COUNTY		Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		24 Lincoln Avenue		d. STREET ADDRESS		Catonsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		DELMA L. LEWIS		4. DATE OF DEATH		March 8 1961		f. AGE (In years last birthday) 58 yrs.	
5. SEX		Female		6. COLOR OR RACE		Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		1902 Dec. 19, 1902		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY		Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. BIRTHPLACE (State or foreign country)		Baltimore, Maryland		13. FATHER'S NAME		Edward H. Moore		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		No		16. SOCIAL SECURITY NO.		219-18-3459		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Arteriosclerotic cardiovascular disease		19. WAS AUTOPSY PERFORMED?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
ACTUAL SIGNATURE		W. Bradley King, Jr., M.D.		23. FUNERAL DIRECTOR		Charles R. Law - 802 Madison Ave., Balto., Md.		24a. REC'D BY REGISTRAR	
EXAMINER'S NAME (Type)		W. Bradley King, Jr., M.D.		24b. REGISTRAR'S SIGNATURE		Arthur S. Kline		DATE	
22a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		22b. DATE THEREOF		3-13-61		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or country)		Baltimore, Maryland		22e. (State)				22f. (County)	



CERTIFICATE OF DEATH

Reg. Dist. No.

02760

2778

1. PLACE OF DEATH a. COUNTY BALTO, MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE MARYLAND b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL RANDALLSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL RANDALLSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3701 - SPRING BELL AVE.		d. STREET ADDRESS 3701 - SPRING BELL AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GLADYS MAY LEWIS		4. DATE OF DEATH Month Day Year 3 7 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 26, 1899
9. AGE (In years last birthday) 61 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 9 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY BOARDING HOUSE	
11. BIRTHPLACE (State or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK F. NEWMAN		14. MOTHER'S MAIDEN NAME GRACE CARR DORSEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO NONE	
17. INFORMANT LORNA GORMAN Address RANDALLSTOWN, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 155.8 CARDIAC FAILURE DUE TO (b) MYXEDEMA DUE TO (c) CARCINOMA COLON		INTERVAL BETWEEN ONSET AND DEATH 1 day 6-7 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-23 , 19 61 , to 3-7 , 19 61 , that I last saw the deceased alive on 3-3 , 19 61 , and that death occurred at 7:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE P. V. Houck M.D.		ADDRESS (Street, city or town, state) Liberty St. Sparrowville, Md. DATE SIGNED 3-7-61	
PHYSICIAN'S NAME (Type) P. V. Houck, Jr. M.D.			
22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL	22b. DATE THEREOF MAR. 10/61	22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM.	
22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.			
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyson Co. ADDRESS 1300 - N ST. N.W. Washington, D.C.		24a. REC'D BY REGISTRAR MAR 10 1961 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Finner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed by the Medical Director, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed by the Medical Director, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed by the Medical Director, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed by the Medical Director, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE
c. LENGTH OF STAY IN TOWN
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8316 Hillendale Rd

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 8316 Hillendale Road
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) EVERETT H. LITCHFIELD
4. DATE OF DEATH March 6, 1961
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 3-1-1910
9. AGE (In years) 51 yrs. 51 Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER 10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Litch Field 14. MOTHER'S MARRIED NAME DORA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 220-09-0398 17. INFORMANT MRS Jessie S. Litchfield Address 8316 Hillendale Road

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) 422.1
(c), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

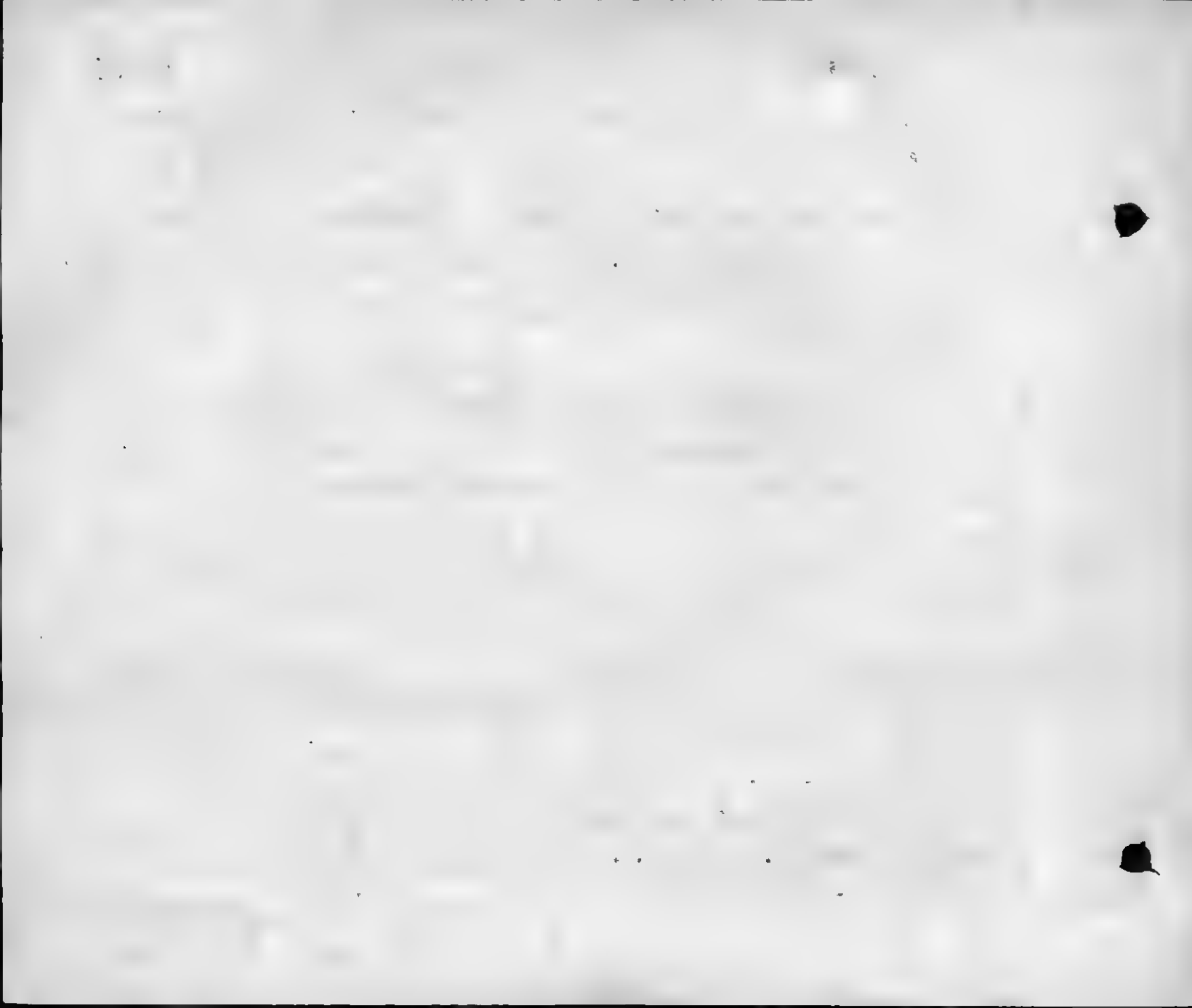
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 3-9-61 20d. INJURY OCCURRED White ☐ Not White ☐ at work ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER ☒ M.D. ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ DATE SIGNED 3/6/61

22. BURIAL, CREMATION, REMOVAL (Specify) 3-9-61 22b. DATE THEREOF 3-9-61 22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer 22d. LOCATION (City, town, or country) (State) BALTIMORE MD

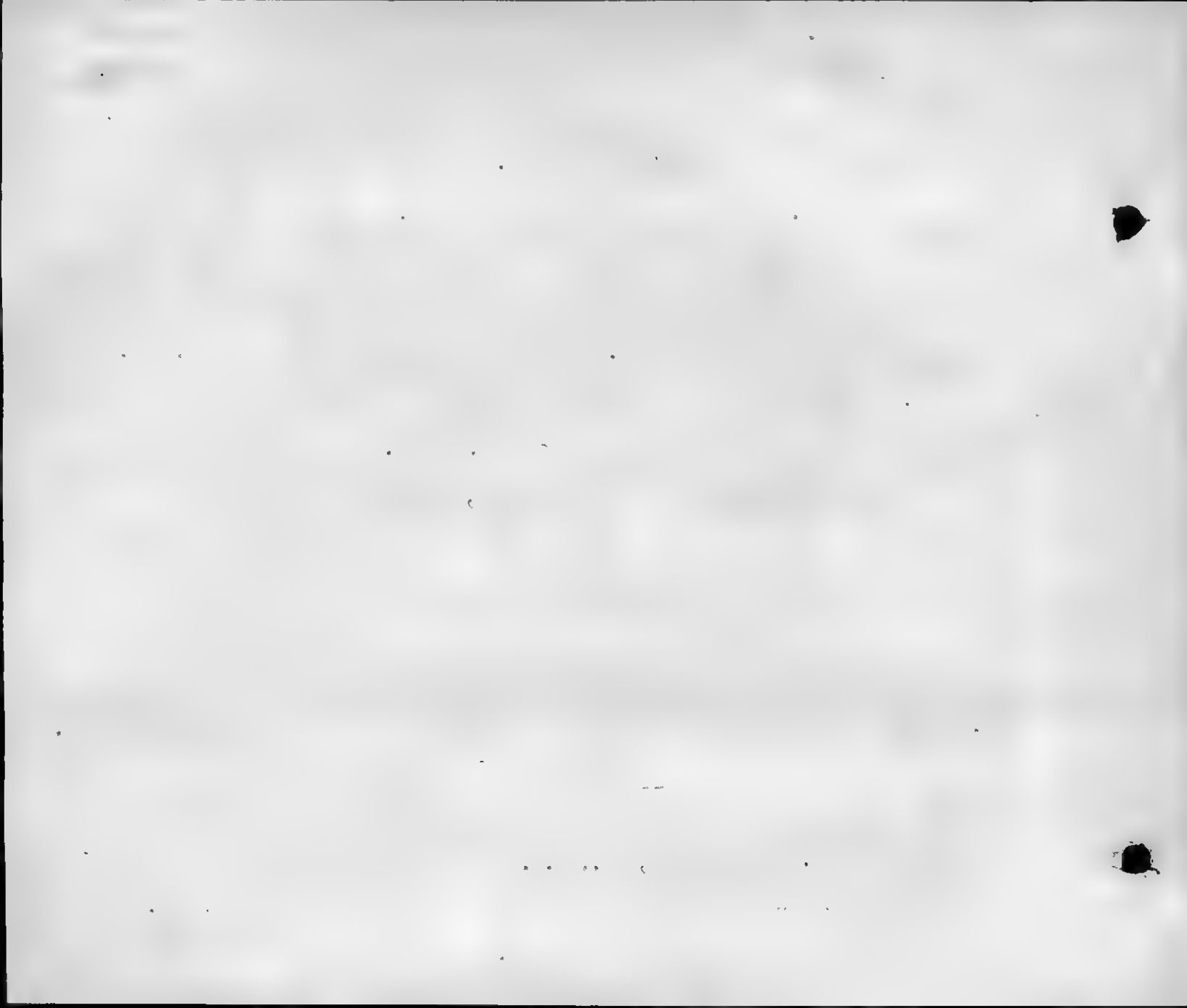
23. FUNERAL DIRECTOR Leonard J. Luck ADDRESS 5305 Nayford 24a. REC'D BY REGISTRAR MAR 9 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Hume



DATE _____

TO DEED: **MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

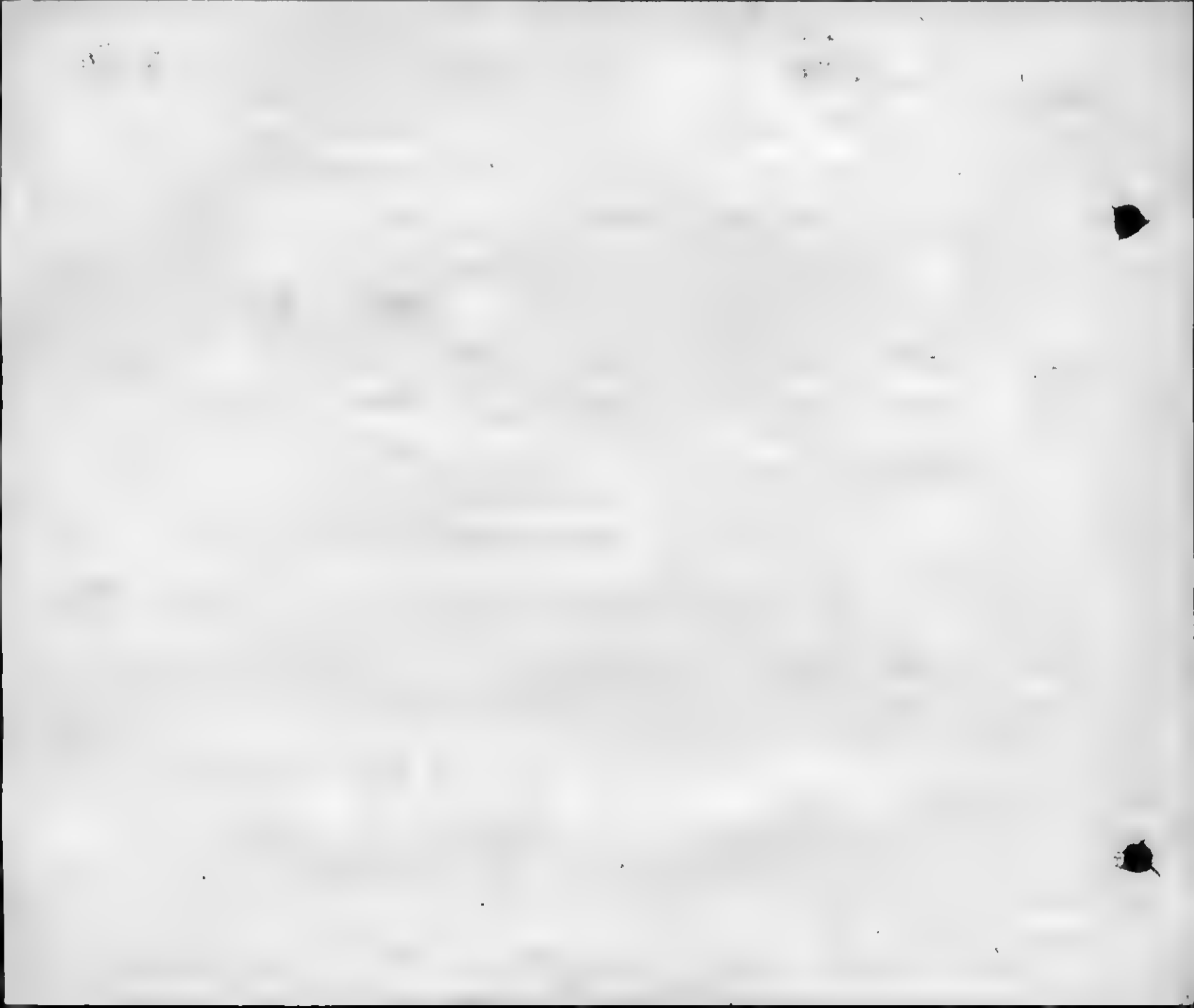
CERTIFICATE OF DEATH

2781

02763

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville Md.</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove State Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore BALTO.</u> d. STREET ADDRESS <u>605 Edgewood Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Herman B. LUTTMER JR.</u> 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>SEPT. 17, 1881</u> 9. AGE (in years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months <u>3</u> Days <u>19</u> IF UNDER 24 HRS.: Hours <u>19</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>unknown MD.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HERMAN B. LUTTMER</u> 14. MOTHER'S MAIDEN NAME <u>MARY</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> 16. SOCIAL SECURITY NO. <u>unknown</u> 17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> (b) <u>420.0</u> DUE TO <u>Arteriosclerotic heart disease with hypertension</u> years (c) <u>Generalized arteriosclerosis</u> years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>none</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, off ice bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-14</u> , 19 <u>61</u> , to <u>3-19</u> , 19 <u>61</u> , that (I) <u>was</u> last saw the deceased alive on <u>3-19</u> , 19 <u>61</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Stella Wachslar, M. D.</u>		22b. DATE SIGNED <u>3-20-61</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u> 22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL Catonsville 28, Md.</u>	
23a. BURIAL, CREMATION, REINTERMENT (Specify) <u>BURIAL</u> 23b. DATE OF <u>3/22/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ST. CHARLES CEM. Pikesville Md.</u> 23d. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE, D. 4101 EDMONDS ON AVE</u> 25a. REC'D BY REGISTRAR <u>MAR 27 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Charles E. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 9/59

2782

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02764

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>		
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2mth2wds</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>			d. STREET ADDRESS <u>1455 Washington Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Joseph</u> Last <u>Maher</u>			4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>19 61</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug; 2, 1900</u>		9. AGE (In years lost birthday) <u>60</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>restaurant manager</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-12-6854</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteri sclerotic c rdiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 10 1961</u> to <u>March 30 1961</u> , that (I) (we) last saw the deceased alive on <u>March 30 1961</u> , and that death occurred at <u>10:20</u> A. M. from the causes and on the date stated above.					
22a. SIGNATURE <u>Stella Wachslor</u>			22b. DATE SIGNED <u>3-30-61</u>		22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslor, M. D.</u>
22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APRIL 3, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Haven</u>	
23d. LOCATION (City, town, or county) <u>H.F. Co. MD</u>		(State)		23e. REC'D BY REGISTRAR <u>DATE APR 3 '61</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>TRED A. COLE</u>		ADDRESS <u>1913 W. BALTO ST.</u>		25. REGISTRAR'S SIGNATURE <u>William S. Hines</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 17, MARYLAND

CERTIFICATE OF DEATH

2783

Item 9 in 6263 3/27/61 iwk

02765

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N.Y.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Larchmont</u>	
3. NAME OF DECEASED (Type or print) <u>Abraham</u> First <u>Bell</u> Middle <u>Malcolmson</u> Last		4. DATE OF DEATH <u>March 17</u> 19 <u>61</u> Month Day Year	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>MAY 9 1879</u> 9 AGE (In years last birthday) <u>81</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Avondale, N.J.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Bell Malcolmson</u>		14. MOTHER'S MAIDEN NAME <u>Julia Bartleson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Spellic R.N.</u> Address <u>College Manor</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> <u>Bronchopneumonia</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>19th</u> to <u>present</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>Mar. 16, 1961</u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Ernest C. Brown Jr</u> M.D.		22b. DATE SIGNED <u>Mar 18, 1961</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>1101 N. Calvert St, Balt-Md</u>	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<u>Removal/Burial</u>		<u>Mar. 21, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Luthern Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Brooklyn, N.Y.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 21 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

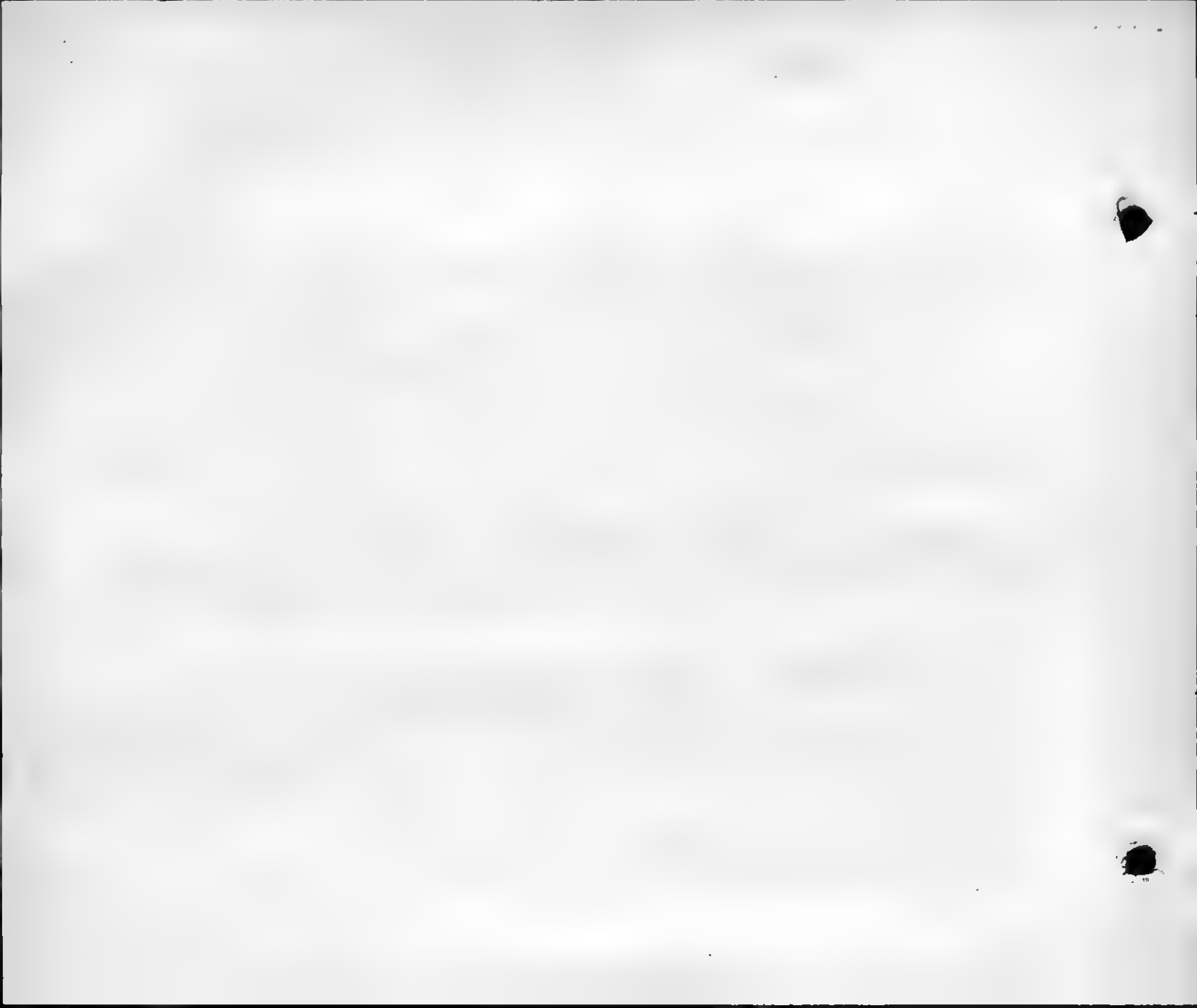
02768

2784

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4512 HARTFORD RD</u>				d. STREET ADDRESS <u>19512 HARTFORD RD</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>FREDERICK</u> Middle <u>MANSEY</u> Last <u>MANSEY</u>				4. DATE OF DEATH Month <u>3</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/6/1885</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>	IF UNDER 24 HRS Hours <u>76</u> Min. <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STORE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Philip MANSEY</u>				14. MOTHER'S MAIDEN NAME <u>ANNA MARIE THEIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-03-5872</u>		17. INFORMANT <u>GEORGIA MANSEY</u>		Address <u>9512 HARTFORD RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>46 coronary heart disease</u> DUE TO <u>intracerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 29, 1961</u> to <u>March 30, 1961</u> , that I last saw the deceased alive on <u>March 29, 1961</u> , and that death occurred at <u>930 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Louis Krause</u> M.D. <u>H. E. CHASE</u> PHYSICIAN'S NAME (Type) <u>LOUIS KRAUSE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/31/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harwood</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. F. EVANS & SON</u>				ADDRESS <u>8802 HARTFORD RD</u>		24a. REC'D BY REGISTRAR DATE <u>SWR A '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>James L. Hume</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2785

CERTIFICATE OF DEATH

Reg. Dist. No. 02767

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EBSOX		c. LENGTH OF STAY IN 1b 8 Months	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1018 S. Bouldin St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 541 South Marlyn Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Marciniak Last Marciniak		4. DATE OF DEATH Month March Day 10 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1888
9. AGE (In years last birthday) yrs. 72		10. IF UNDER 1 YEAR: Months 7 Days 21 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Labor Dept.		10b. KIND OF BUSINESS OR INDUSTRY Standard Oil Co.	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A..	
13. FATHER'S NAME George Marciniak		14. MOTHER'S MAIDEN NAME Veronica Papirowski	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 214-01-4600	
17. INFORMANT Mrs. Helen Marciniak		Address 1018 S. Bouldin St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5-10-5	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/18 , 19 59 to 3/10 , 19 61 , that I last saw the deceased alive on 3/10 , 19 61 , and that death occurred at 9:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Benjamin H. Hester		ADDRESS (Street, city or town, state) 121 S. HILLYARD AVE BALTO 24 MD	
PHYSICIAN'S NAME (Type) DR. BENJAMIN H. HESTER		DATE SIGNED 3/11/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-13-1961	
22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		22d. LOCATION (City, town, or county) (State) Dundalk Ave. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		ADDRESS 2829 Hudson St. 24, Md.	
24a. REC'D BY REGISTRAR DATE MAR 14 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

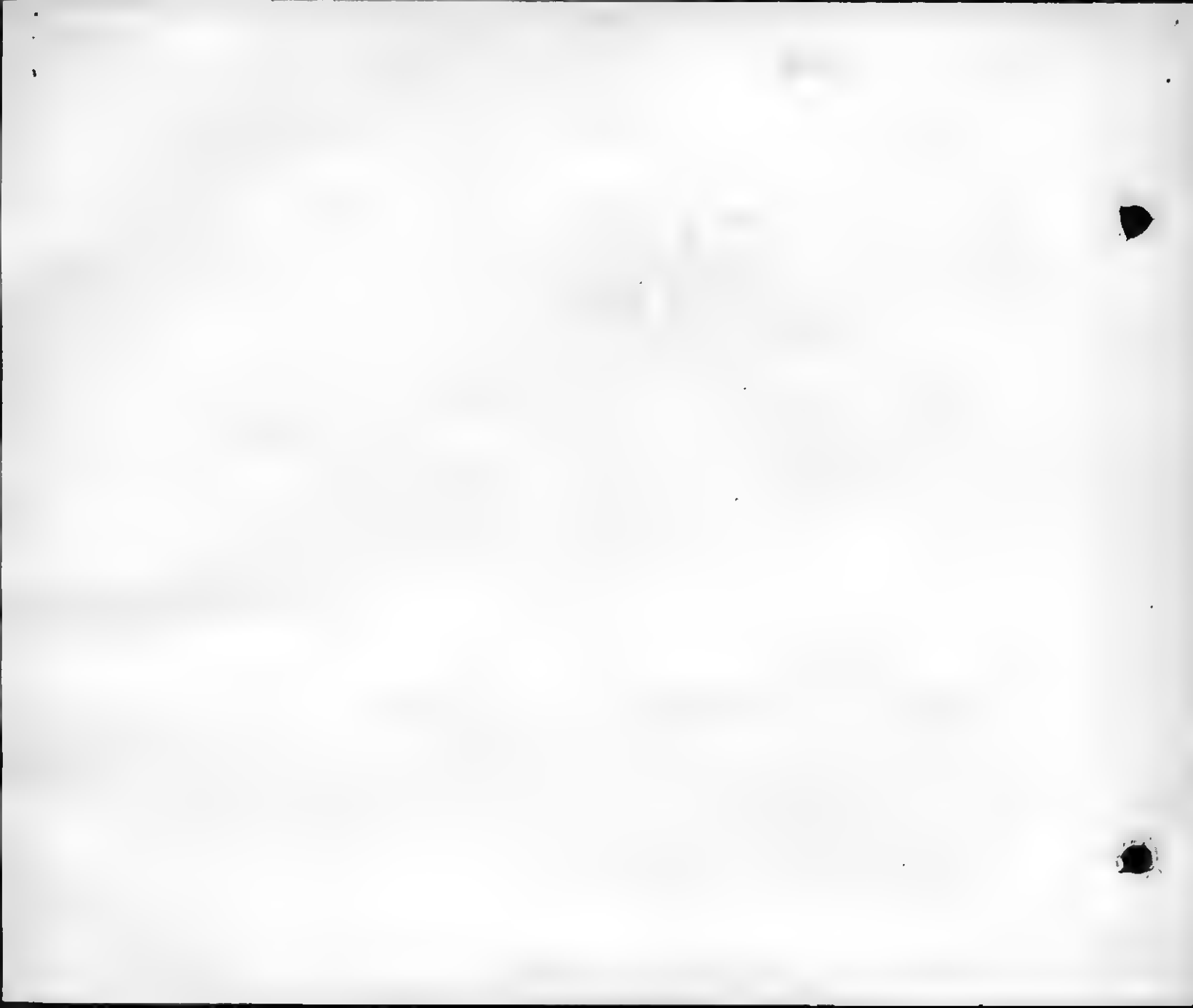
02768

2786

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARNEY				c. LENGTH OF STAY IN 1b 6 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8639 RICHMOND AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KATHERINE VIRGINIA MCCADDIN				4. DATE OF DEATH MARCH 12 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/28/1878	
9. AGE (In years lost birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN WEBER				14. MOTHER'S MAIDEN NAME MARIA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NCIVE		17. INFORMANT H.D. MCCADDIN Address 8639 RICHMOND AVE.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) senility DUE TO (c) senility INTERVAL BETWEEN ONSET AND DEATH 4-6 yrs							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 3/6 , 19 61 , to 3/12 , 19 61 , that I last saw the deceased alive on 3/6 , 19 61 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Theodore J. Graziano M.D.				ADDRESS (Street, city or town, state) 2802 Hayden Rd DATE SIGNED 3/13/61			
PHYSICIAN'S NAME (Type) Theodore J. Graziano							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/15/61		22c. NAME OF CEMETERY OR CREMATORY PARKWOOD		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE B.W. Koffmann ADDRESS 3218 HUDSON ST.				24a. REC'D BY REGISTRAR DATE MAR 14 '61		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

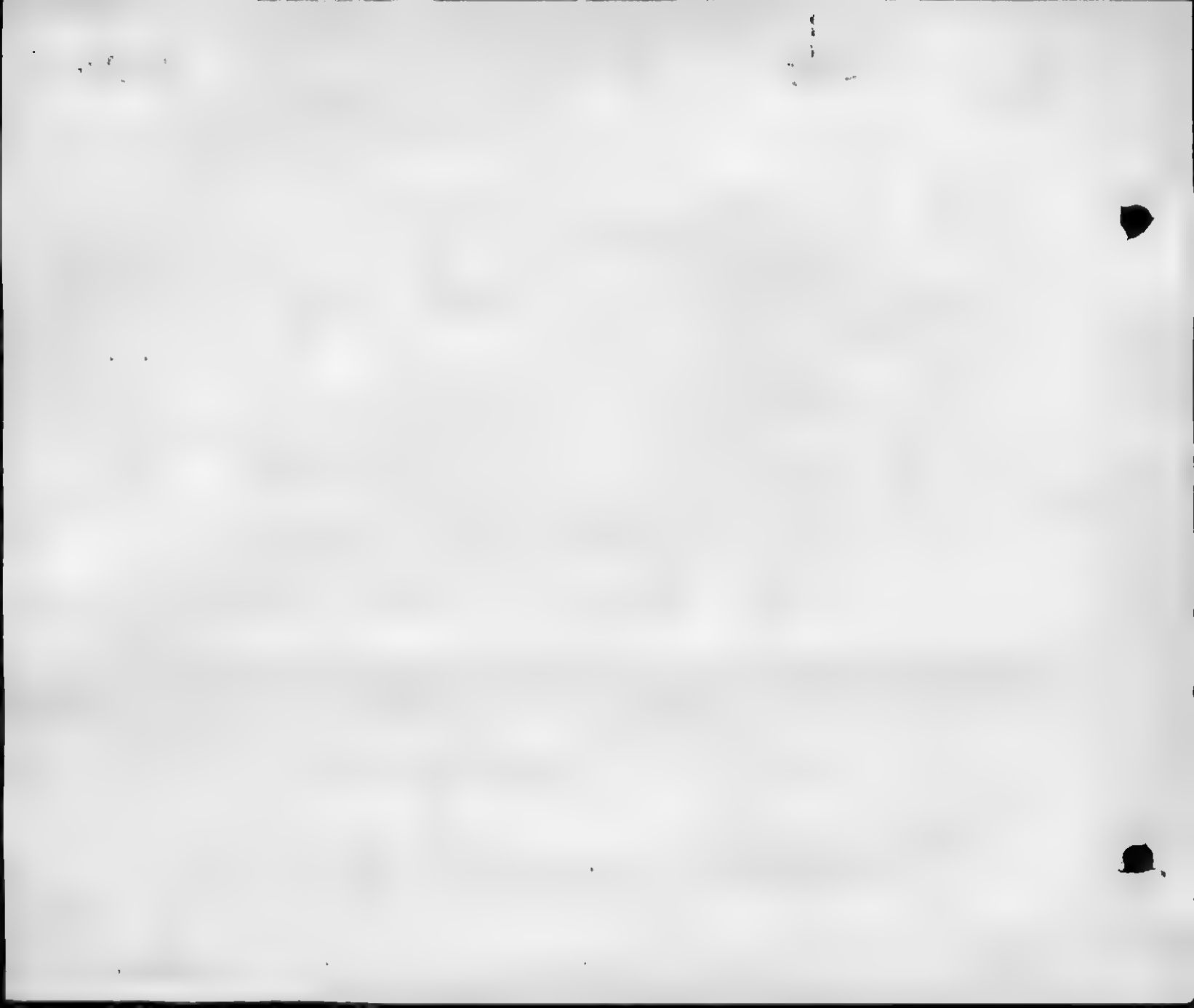
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
2787									
02769									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Catonville</u> c. LENGTH OF STAY IN 1b <u>4yr3mth7dys</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Timonium, Maryland</u> d. STREET ADDRESS <u>40 Gorsuch Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Laura</u>					4. DATE OF DEATH Last <u>McCoy</u> Month <u>March</u> Day <u>14</u> Year <u>1961</u>				
5. SEX <u>female</u>					6. COLOR OR RACE <u>white</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>1885?</u>				
9. AGE (In years last birthday) <u>75</u> yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>					12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				
13. FATHER'S NAME <u>Thomas Murphy</u>					14. MOTHER'S MAIDEN NAME <u>Mary Helems</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>					16. SOCIAL SECURITY NO. <u>unknown</u>				
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease</u> (c) <u>Arteriosclerotic cardiovascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>May 19, 1959</u> to <u>March 14, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 14, 1961</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Stella Wachslar, M. D.</u>									
22b. DATE SIGNED <u>3-14-61</u>									
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>									
22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonville 28, Maryland</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>									
23b. DATE THEREOF <u>3/15/61</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>									
23d. LOCATION (City, town or county) (State) <u>BALTO. M.D.</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE F.D.</u> ADDRESS <u>4101 EDMONDSON AVE.</u>									
25a. REC'D BY REGISTRAR <u>DATE MAR 16 '61</u>									
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>									



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose it in a separate envelope, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

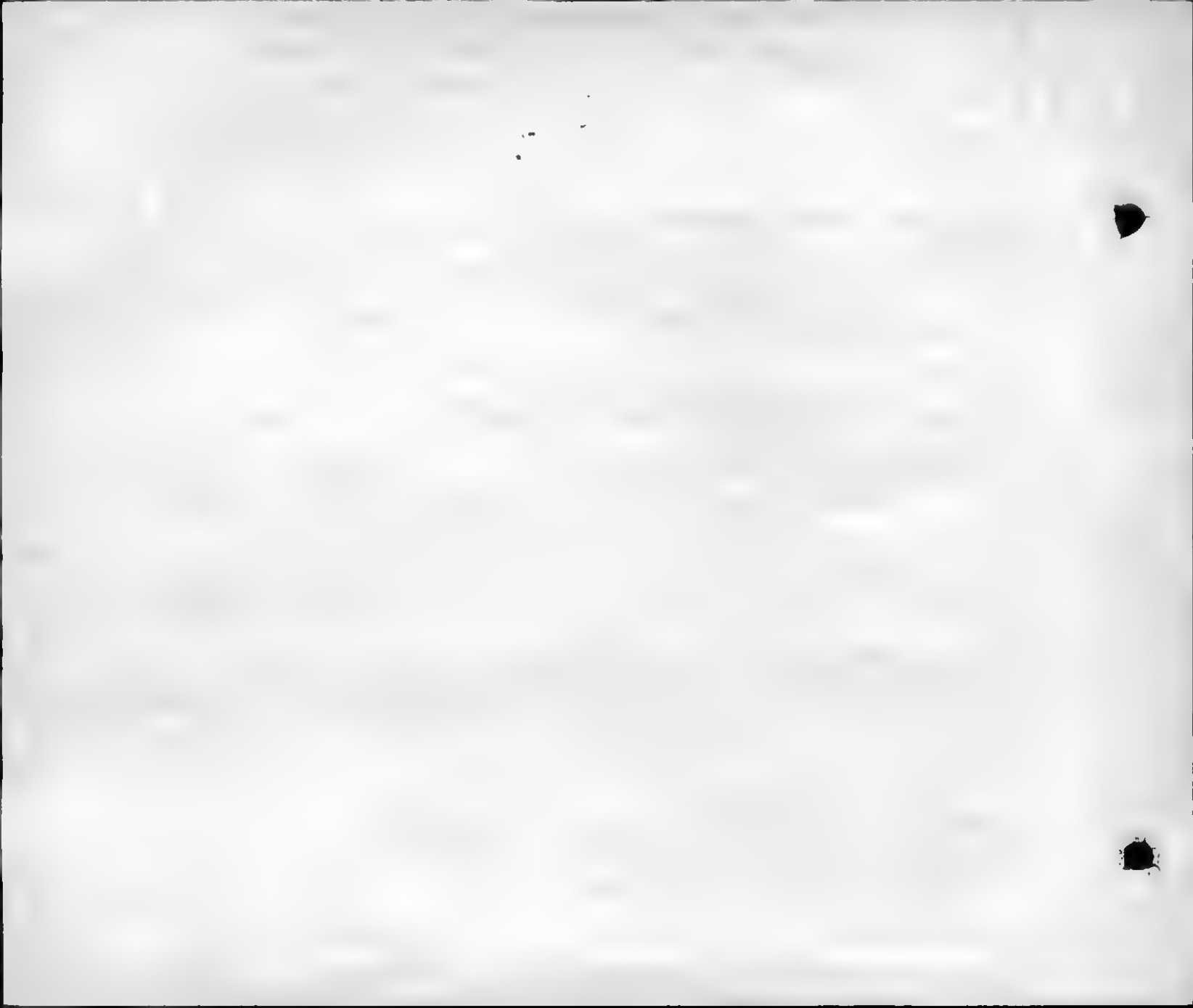
Reg. Dist. No.

02770

2788

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JONES' CREEK (19)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JONES' CREEK (19)			
c. LENGTH OF STAY IN lb LIFE				d. STREET ADDRESS 7346 HUGHES AVE.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7346 HUGHES AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARGIE LYNN MCGROGAN				4. DATE OF DEATH MAR. 3, 1961			
5. SEX FEM.		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 4, 1961	
9. AGE (In years last birthday) 0 yrs.		IF UNDER 1 YEAR Months 7 Days 29		IF UNDER 24 HRS. Hours Min 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) MARYLAND (city)	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ROBERT S. MCGROGAN				14. MOTHER'S MAIDEN NAME BERNICE E. SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 				16. SOCIAL SECURITY NO. 			
17. INFORMANT BERNICE E. SMITH - MOTHER				Address 5415 E. 52-ABC D			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① BRONCHIAL PNEUMONIA DUE TO ② BRONCHITIS Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. 491 X							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) NONE			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M.B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M.B. Davis MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/6/61		22c. NAME OF CEMETERY OR CREMATORY OAK LAWN		22d. LOCATION (City, town, or county) (State) BALTO Co. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. R. Bodley - Funeral Home				24a. REC'D BY REGISTRAR DATE MAR 8 '61		24b. REGISTRAR'S SIGNATURE Charles L. Kraus	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2789

CERTIFICATE OF DEATH

02771

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 30 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY SVCI-4 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4215 Wickford Road, Baltimore 10, Md. d. STREET ADDRESS 4215 Wickford Road	
3. NAME OF DECEASED (Type or print) CHARLES MELVIN McLAUGHLIN		4. DATE OF DEATH Month March Day 30 Year 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 20, 1908	
9a. AGE (In years last birthday) 52 yrs.		9b. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman		10b. KIND OF BUSINESS OR INDUSTRY Odd Jobs	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James M. McLaughlin		14. MOTHER'S MAIDEN NAME Mary Ford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 216-05-7286	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS, FAR ADVANCED, ACTIVE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) SQUAMOUS CELL CARCINOMA, PHARYNX, WITH METASTASIS TO RIGHT CERVICAL LYMPH NODES (c) ARTERIOSCLEROSIS, GENERALIZED PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) UNKNOWN UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) NO		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from February 28, 1960 , to March 30, 1961 , that (u) (we) last saw the deceased alive on March 30, 1961 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan		22b. DATE 3/30/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-6-61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14		25a. REC'D BY REGISTRAR APR 3 '61	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. If age 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2790

CERTIFICATE OF DEATH

02772

1. NAME OF DECEASED (Type or Print) ELVIRA MCCOY		2. DATE OF DEATH 3/19/61	
3. PLACE OF DEATH a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MD b. COUNTY Harford Co.	
b. FULL NAME OF HOSPITAL OR INSTITUTION 5743 Ed. Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Harford Co.	
c. Length of stay in Baltimore Catharine St.		d. STREET ADDRESS (If rural, give location) 12X-2	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH 3-26-1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) 3. Fair Md	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME LOUIS JONES		14. MOTHER'S MAIDEN NAME Elizabeth HUGHES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	(A) Respiratory failure		
	DUE TO		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) Heart failure		
	DUE TO		
	(C) Stroke		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY?
22. I certify that (I) (this hospital) attended the deceased from March 19, 1961 to March 22, 1961 , that (I) (we) last saw the deceased alive on March 22, 1961 , and that death occurred at 11:00 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE William L. Thomas M.D.	23b. ADDRESS 177 The Falls Road	23c. DATE SIGNED 3/19/61	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE March 22, 1961	24c. NAME OF CEMETERY OR CREMATORY DARLINGTON CEMETARY	24d. LOCATION (City, town, or county) (State) HARFORD - CO-MD
DATE RECEIVED BY LOCAL REGISTRAR March 21, 1961	REGISTRAR'S SIGNATURE William L. Thomas	25. FEDERAL DIRECTOR ADDRESS AS Bailer Darlington	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 8/59

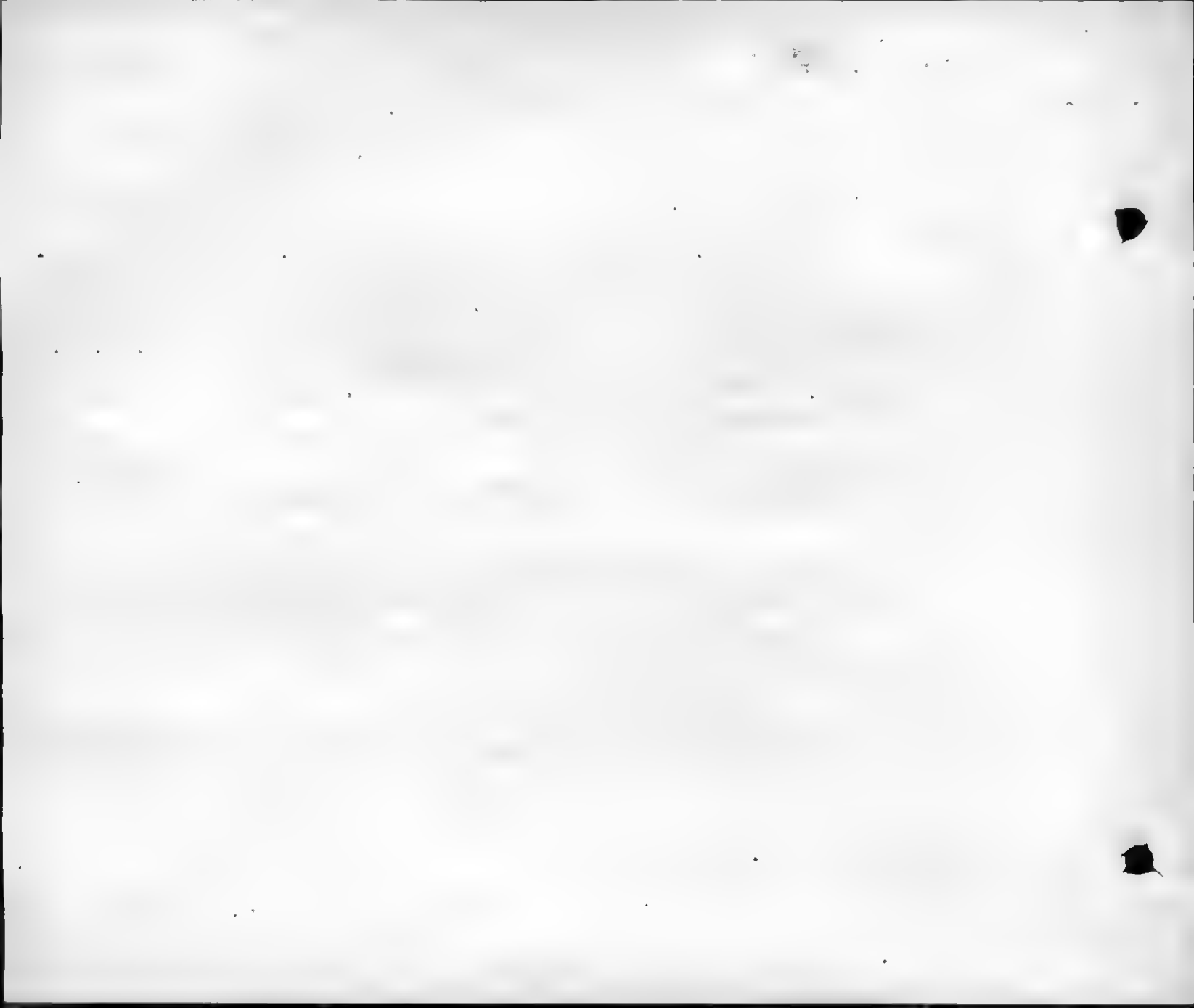
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2791

CERTIFICATE OF DEATH

02773

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4409 John Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Georgia L. Middle Melia Last 		4. DATE OF DEATH Month March Day 23 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1879
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William G. F. Groomes		14. MOTHER'S MAIDEN NAME Almira A. Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO none	
17. INFORMANT Leo Melia 4409 John Avenue		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerosis C.V. Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 19 56 to March 23 19 61 , that (I) (we) lost the deceased alive on March 23 1961 , and that death occurred at M , from the causes and on the date stated above			
22a. SIGNATURE John F. Coolahan M.D.		22b. DATE SIGNED 3/23/61	
22c. PHYSICIAN'S NAME (Type) John F. Coolahan		22d. ADDRESS Wilkins Avenue	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/27/61	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR MAR 27 '61	
ADDRESS 4107 Wilkins Avenue		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

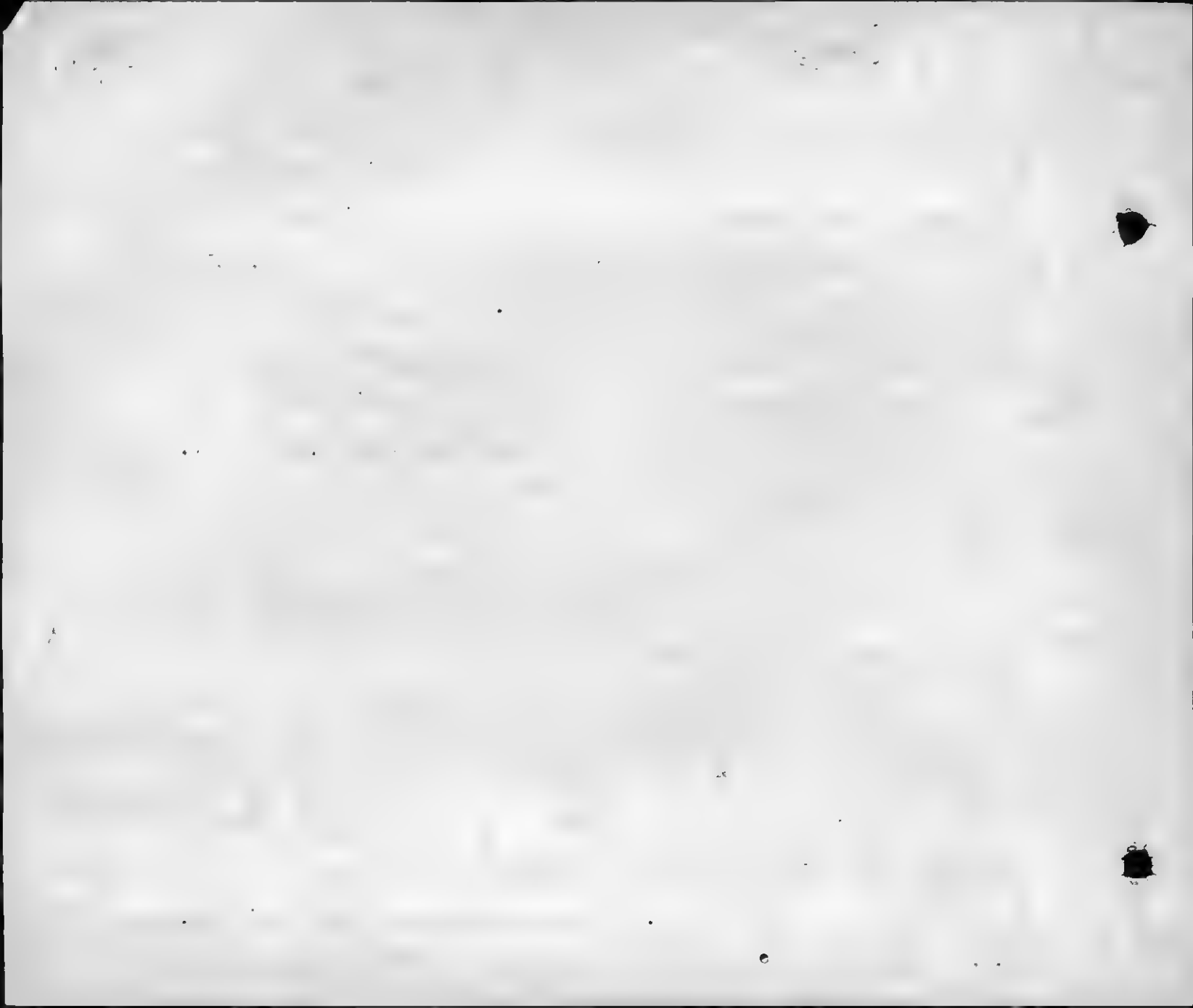
1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2792 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02774

Items 2c & d, film G203 3/4/61 iwk

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN lb 11 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Forest Haven Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville Ellicott City d. STREET ADDRESS Main Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY CATHERINE MELLOR		4. DATE OF DEATH Mar. 14, 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 29, 1868	
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Cotterill		14. MOTHER'S MAIDEN NAME Margaret Ann Winebrenner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Elwood Mellor, 1405 N. Charles St. Baltimore 1 Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized atherosclerosis DUE TO (c) Coronary vascular disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. S. M. Kilgus		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DR. S. M. KILGUS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Incl 14-1961	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) 1010 Leach ave	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-17-61	
22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or country) (State) Ellicott City Md.	
23. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR MAR 16 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



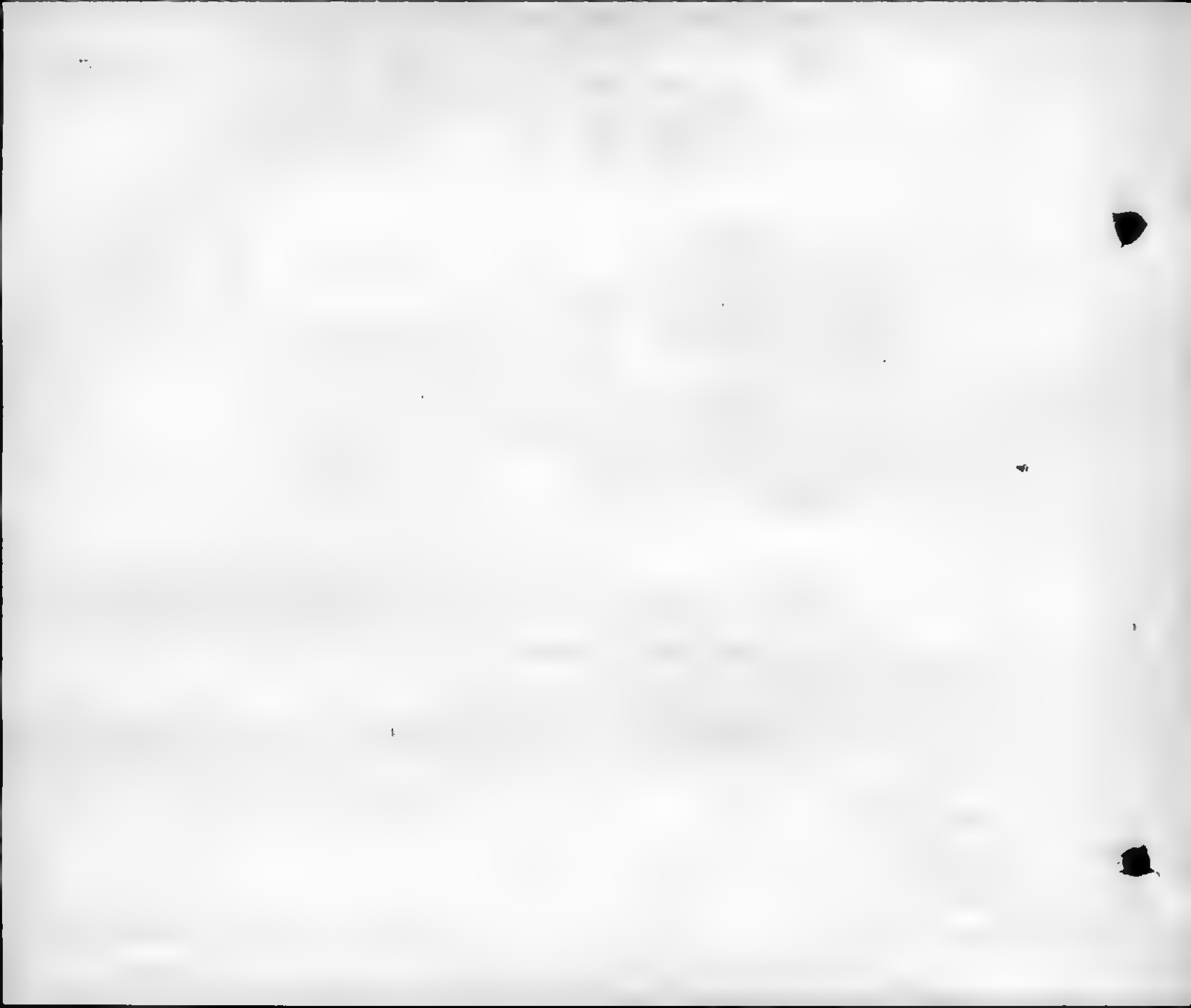
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2793
CERTIFICATE OF DEATH

Reg. Dist. No. **02775**

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto H. & I.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u>		c. LENGTH OF STAY in 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marriottsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Melrose Road</u>				d. STREET ADDRESS <u>Marriottsville Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Francis Charles Mentzell</u>				4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 12, 1915</u>	
				9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>							
13. FATHER'S NAME <u>Samuel Kent Mentzell</u>				14. MOTHER'S MAIDEN NAME <u>Mary M. Ewing</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes 1956-1957</u>		16. SOCIAL SECURITY NO. <u>219-16-6549</u>		17. INFORMANT <u>Edna May Mentzell - wife</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3-16</u> , 19 <u>61</u> , to <u>3-21</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>3-20</u> , 19 <u>61</u> , and that death occurred at <u>5:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles H. Williams</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>1632 Reisterstown Road</u>			
PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u>				<u>P. H. Hesville 8, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/23/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Pyper</u> ADDRESS <u>8728 Fether Rd. Rockville, Md.</u>				24a. RECEIVED BY REGISTRAR DATE <u>2-3-61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 5 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

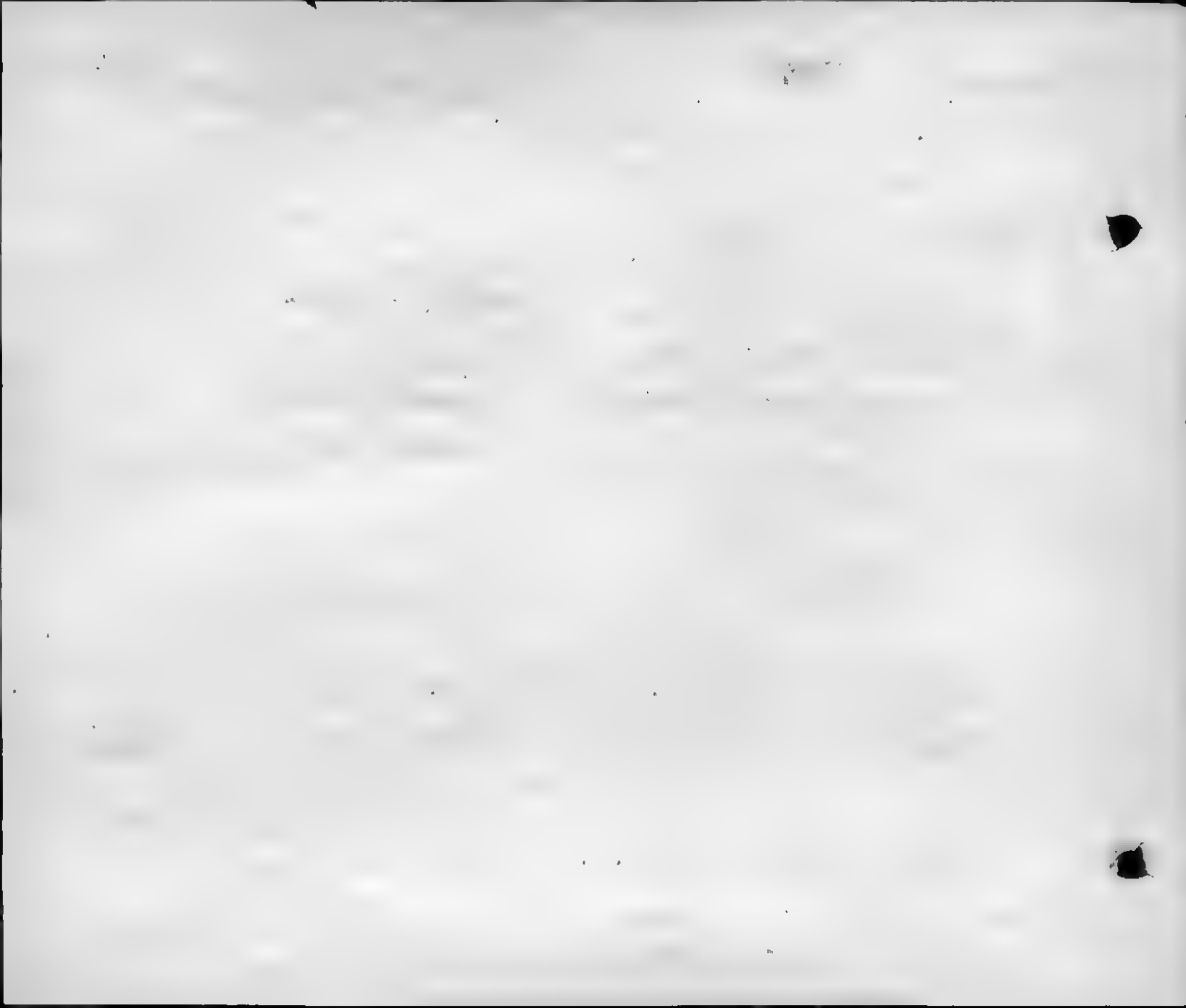
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. PLACE OF DEATH a. COUNTY Baltimore</p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY ✓</p>	
<p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville</p>		<p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore</p>	
<p>c. LENGTH OF STAY IN 1b 11mth28dys</p>		<p>d. STREET ADDRESS 3212 Ferndale Avenue</p>	
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL</p>		<p>IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) William D. Mesenzehl</p>		<p>4. DATE OF DEATH Month March Day 29 Year 1961</p>	
<p>5. SEX male</p>		<p>6. COLOR OR RACE white</p>	
<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH FEB. 17/18/1908</p>	
<p>10a. USUAL OCCUPATION (Give kind of work, including most of working life, even if retired) RETIRED ASST. MANAGER, RITE CARLTON</p>		<p>11. BIRTHPLACE (State or foreign country) Maryland</p>	
<p>13. FATHER'S NAME JOSEPH MESENZEL</p>		<p>14. MOTHER'S MAIDEN NAME HANNAH</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown</p>		<p>16. SOCIAL SECURITY NO. 066-05-0199</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 452 Acute cardiac failure DUE TO (b) Generalized arteriosclerosis DUE TO (c) Cardiovascular disease</p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) Records: SPRING GROVE STATE HOSPITAL</p>		<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) On 3-16-61 the patient complained of pain in left hip; bruising noticed; exact cause not known. X-ray showed fracture of left pubic and ischial bones.</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour, a.m. 8:00pm 3-16-61</p>		<p>20d. PLACE OF INJURY (Home, farm, factory, street, or off bldg., etc.) hospital</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>		<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3-29-61</p>	
<p>ACTUAL SIGNATURE George M. Kieffer, M.D.</p>		<p>DATE SIGNED</p>	
<p>EXAMINER'S NAME (Type) George M. Kieffer, M.D.</p>		<p>Address (Street, city, town, or county) BALTO. MD.</p>	
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION</p>		<p>22b. DATE THEREOF 4/1/61</p>	
<p>22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL</p>		<p>22d. LOCATION (City, town, or county) (State) BALTO. MD.</p>	
<p>23. FUNERAL DIRECTOR WITZKE F.D. 4101 EDMONDSON AVE.</p>		<p>24a. REC'D BY REGISTRAR APR 4 '61</p>	
<p>24b. REGISTRAR'S SIGNATURE Arthur L. Kneiss</p>		<p>24c. REGISTRAR'S SIGNATURE</p>	

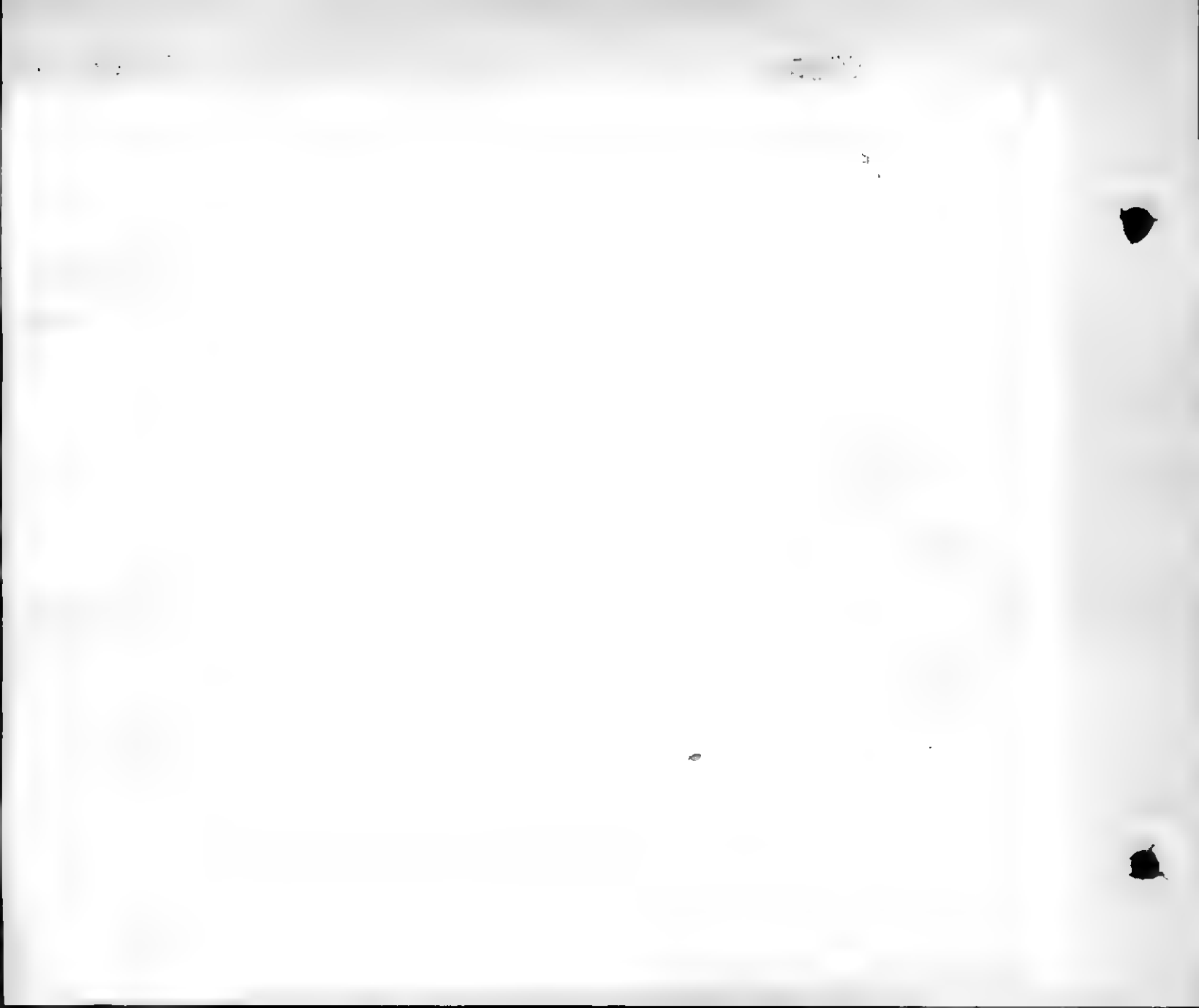
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed and signed by the funeral director. After this certificate has been signed by the attending physician and completed and signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2795
CERTIFICATE OF DEATH
02777

1. NAME OF DECEASED (Type or Print) FRANK MESZAROS		2. DATE OF DEATH MARCH 6, 1961				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Baltimore County Catonville House in the Pines		4. USUAL RESIDENCE (Where deceased lived If institution residence before admission) A. STATE MARYLAND B. COUNTY SV-1 C. CITY OR TOWN BALTIMORE (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 4405 ANNTANA AVE				
5. SEX MALE	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JUNE-22-1875	9. AGE (In years last birthday) 85	If Under 1 Year Months Days Hours Min.	If Under 24 Hours Hours Min.
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL MINER		10. B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) HUNGARY		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Joseph		14. MOTHER'S MAIDEN NAME UNKNOWN		17. INFORMANT MARGARET SWINSKIE 4405 ANNTANA AVE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		ADDRESS		
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 44BX (A) Chronic bronchitis DUE TO (B) Chronic emphysema DUE TO (C) Chronic obstructive pulmonary disease DUE TO INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs 10 yrs 20 yrs						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Smoking						
19. A. DATE OF OPERATION 3-5-1961		19. B. CONDITION FOR WHICH OPERATION WAS PERFORMED removal of gallbladder		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 3-5-1961 to 6-12-1960 and that in (my) (our) opinion death occurred at 3-5-1961 from the causes and on the date stated above						
23A. SIGNATURE ATTENDING PHYSICIAN John A. [unclear] MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> M. D.		23B. ADDRESS 6257 [unclear] [unclear] [unclear] [unclear]		23C. DATE SIGNED 3-7-61		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/10/61		24C. NAME OF CEMETERY OR CREMATORY HOLY CROSS Cem.		24D. LOCATION (City, town, or county) (State) CHARLESBURG W. VA.
25A. DATE REC'D BY HEALTH DEPT. MAR 8 '61		25B. NAME OF REGISTRAR Arthur L. [unclear]		25C. FUNERAL DIRECTOR Joseph N. [unclear] 3125 Highland Ave		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

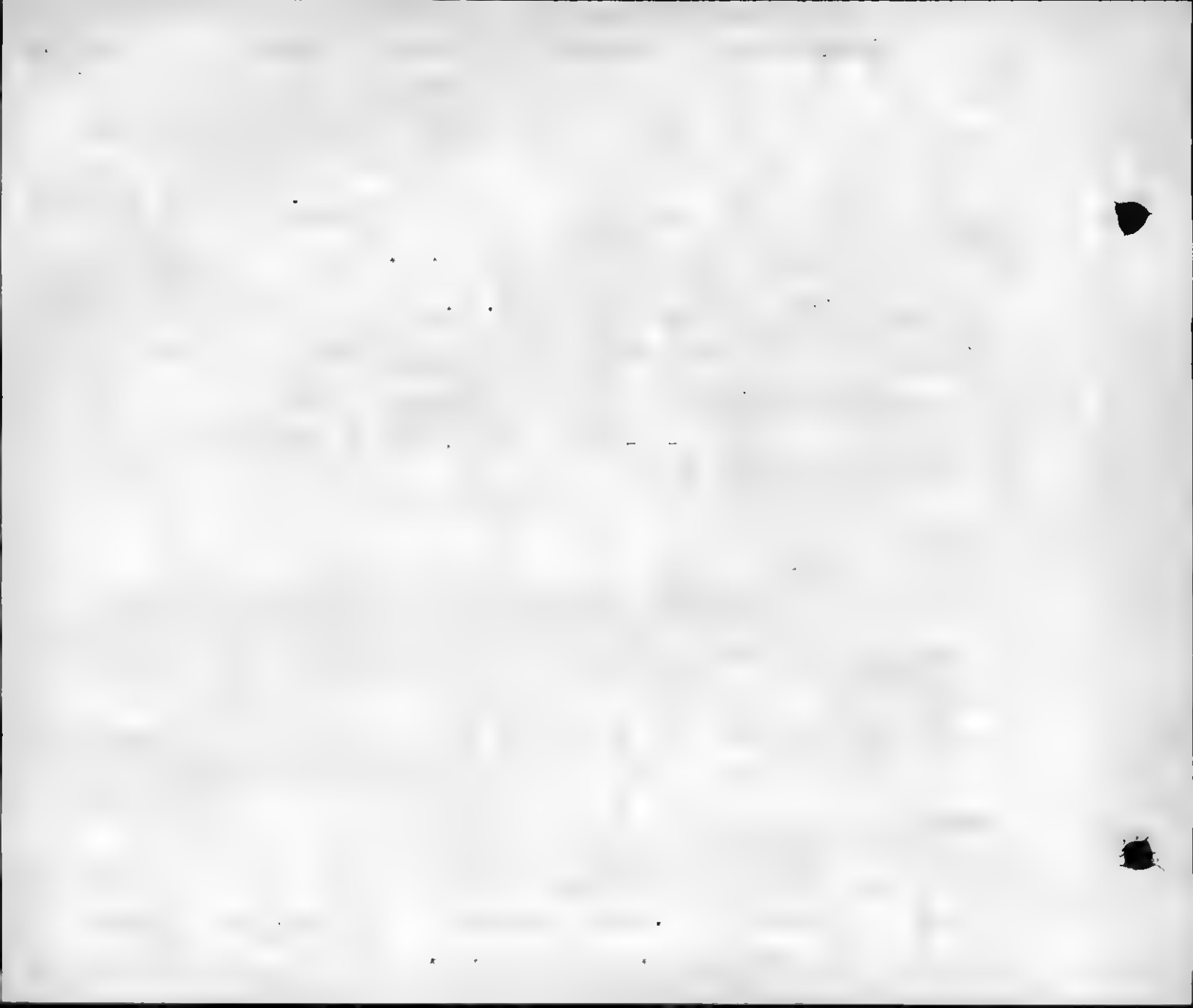
2796 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02778**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. LENGTH OF STAY IN 1b 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1915 Rottman Lane				d. STREET ADDRESS 1915 Rottman Lane			
3. NAME OF DECEASED (Type or print) James CARL First Middle Last Mitchem, Sr.				4. DATE OF DEATH Month 3 Day 16 Year 1961			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 29, 1904		9. AGE (In years last birthday) 57 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Soft Coal		11. BIRTHPLACE (State or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Nelson Mitchem			14. MOTHER'S MAIDEN NAME Margaret Evans				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 236-05-6095		17. INFORMANT Address Ruby A. Mitchem same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ch Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 7 Months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ e. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Jack O Collins</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3-16-61		
EXAMINER'S NAME (Type) Jack O Collins			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/19/61		22c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Cemetery			
22d. LOCATION (City, town, or county) (State) Beckley, West Virginia		23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md.					
24a. REC'D BY REGISTRAR DATE MAR 20 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2
may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2797

CERTIFICATE OF DEATH

02779

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>7 yrs</u>		d. STREET ADDRESS <u>3502 Clifton Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris Hospice</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Monmonier</u> Last <u>Monmonier</u>		4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-13-1869</u>
9. AGE (In years lost birthday) <u>91</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>3</u> Days <u>14</u> Hours <u>14</u> Min <u>41</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Valley Valley Road</u>	
11 BIRTHPLACE (State or foreign country) <u>USA</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>George Monmonier</u>		14. MOTHER'S MAIDEN NAME <u>Mary McMagh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Sister Mary Celeste, R.S.M. - Stella Maris</u>		Address <u>Stella Maris</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4/11/1</u> DUE TO <u>Ventricular Fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>Coronary thrombosis</u> DUE TO <u>Ascid</u> (b) <u>Ascid</u> (c) <u>Ascid</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>August 1960</u> to <u>March 13, 1961</u> , that (I) (we) last saw the deceased alive on <u>3/13</u> 1961, and that death occurred at <u>12:15</u> P. M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert J. Mahon</u>		22b. DATE SIGNED <u>3/14/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert J. Mahon, M.D.</u>		22d. ADDRESS <u>602 E. Joppa Road, Towson 4, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/16/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u>		25a. REC'D BY REGISTRAR <u>3000 E. Baltimore St. Balto.</u>	
25b. REGISTRAR'S SIGNATURE <u>3000 E. Baltimore St. Balto.</u>		DATE <u>MAR 17 '61</u>	

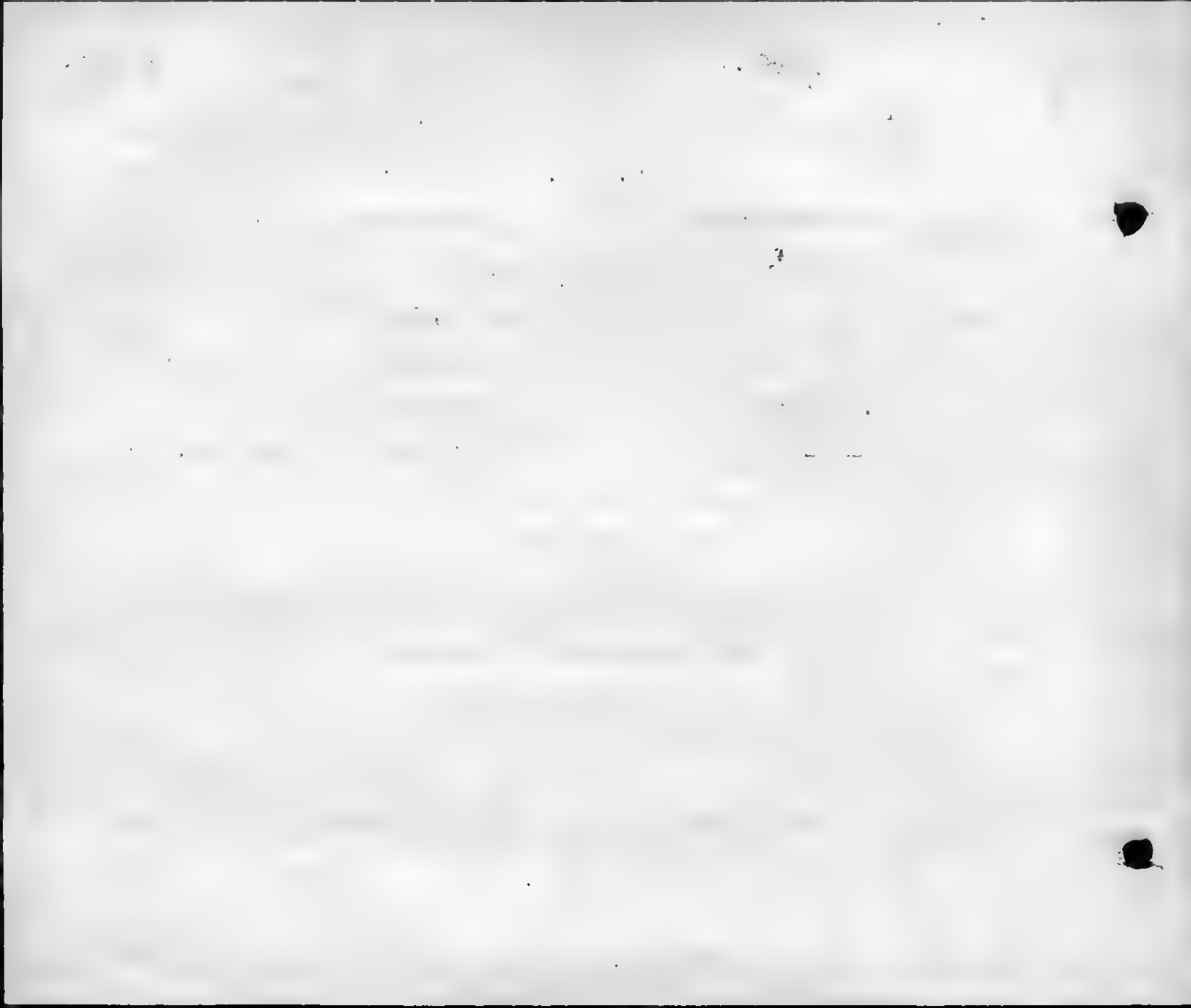


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2798 CERTIFICATE OF DEATH 02780

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN 1b <u>29 yrs. 3 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Training School</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. CITY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>604 South Smallwood Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Agnes</u> Last <u>Montague</u> 4. DATE OF DEATH <u>March 5 1961</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>January 10, 1925</u> 9. AGE (in years last birthday) <u>36</u> yrs. IF UNDER 1 YEAR: Months <u>5</u> Days <u>19</u> Hours <u>61</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A?</u>		13. FATHER'S NAME <u>Charles F. Montague</u> 14. MOTHER'S MAIDEN NAME <u>Barbara Bauer</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Rosewood records</u> Address <u>Owings Mills, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 129.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Multiple congenital anomalies</u> (c) <u>Multiple congenital anomalies</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>3-4-1961</u> Hour a.m. <u>3:50</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>4307 Mainfield Ave Balto</u> 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-4-1961</u> , to <u>3-5-1961</u> , that (I) (we) last saw the deceased alive on <u>3-5-1961</u> , and that death occurred at <u>3:50</u> M, from the causes and on the date stated above.		22a. SIGNATURE <u>Peter W. Rieckert</u> 22b. DATE SIGNED <u>3-5-61</u> 22c. PHYSICIAN'S NAME (Type) <u>Peter W. Rieckert</u> 22d. ADDRESS <u>4307 Mainfield Ave Balto</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>3/7/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u> 23d. LOCATION (City, town or county) (State) <u>BALTO. MD.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE F.D.</u> ADDRESS <u>4101 EDMONDSON AVE.</u> 25a. REC'D BY REGISTRAR <u>MAR 7 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2799

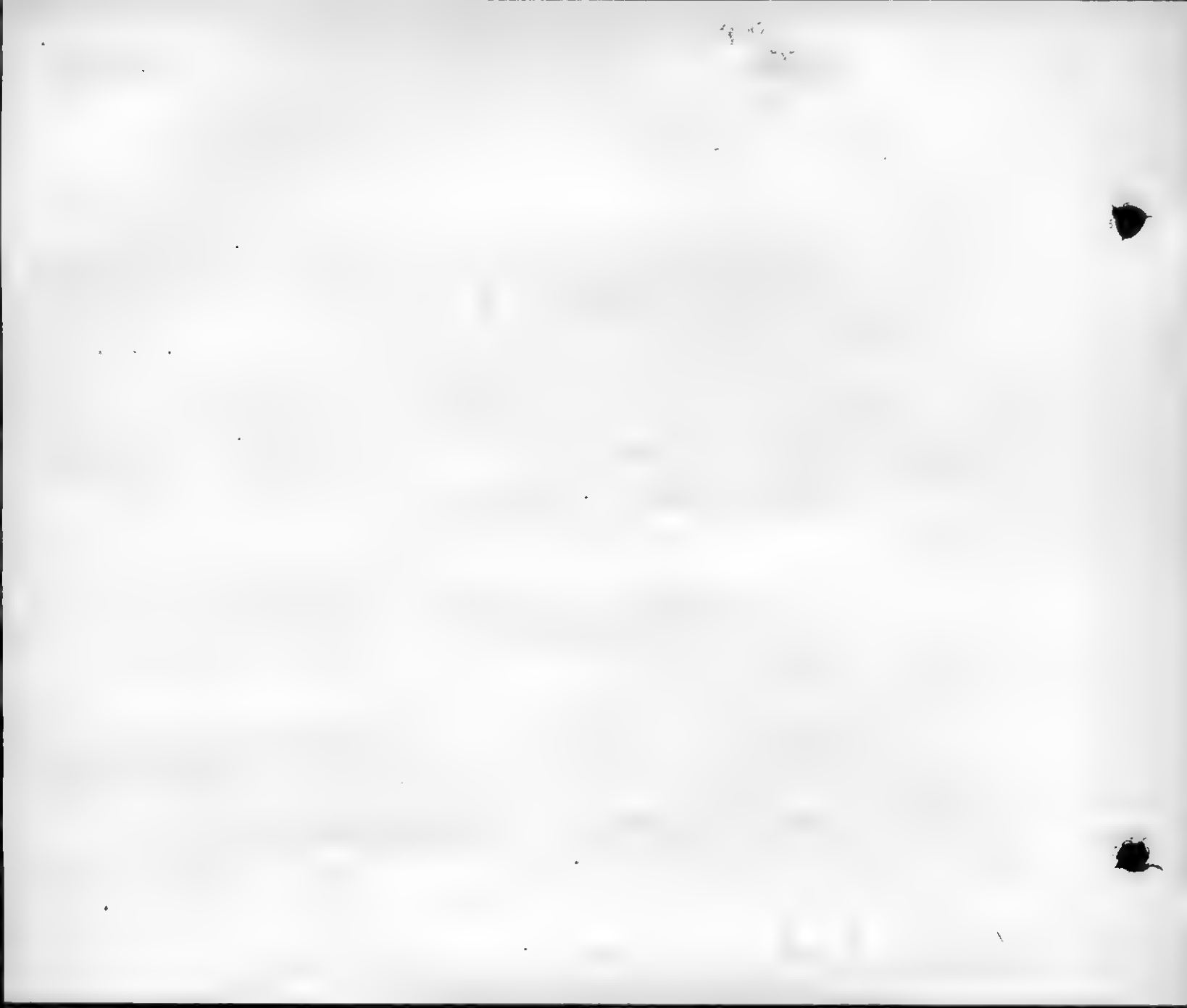
CERTIFICATE OF DEATH

02781

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hattie Middle Anna Last Moody		4. DATE OF DEATH Month March Day 24 Year 19 61	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1891
9. AGE (In years lost birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 69 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 9, 1961 to March 23, 1961 , that (I) (we) last saw the deceased alive on March 23, 1961 , and that death occurred at 4:40 p. m. from the causes and on the date stated above			
22a. SIGNATURE Stella Wachler		22b. DATE SIGNED 3-24-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-27-1961	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City, town, or county) (State) Howard County Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frederick & Wade Ave; 28		25a. REC'D BY REGISTRAR MAR 28 '61	
25b. REGISTRAR'S SIGNATURE Caroline S. Kinn			

M

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

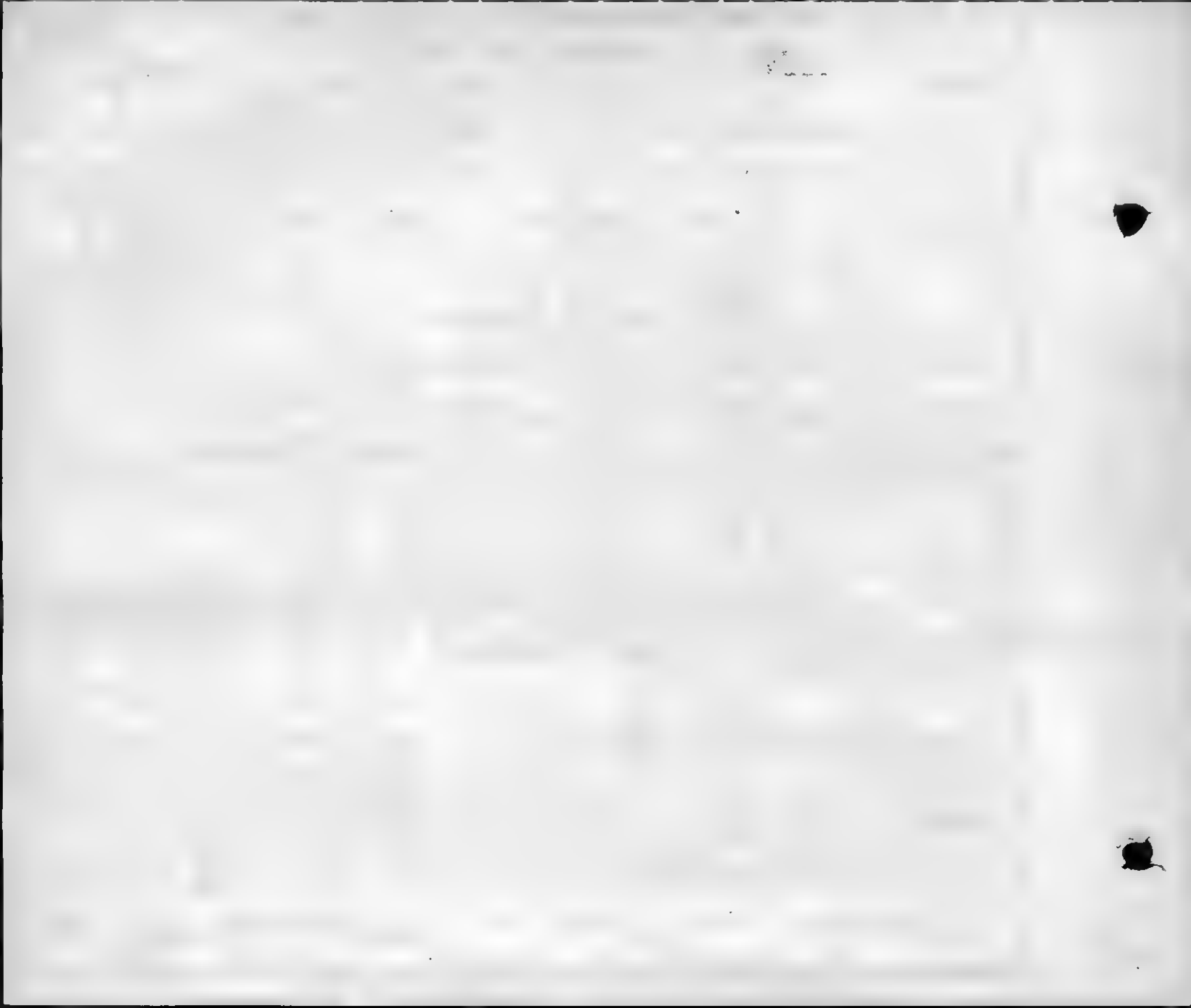
2800

CERTIFICATE OF DEATH

Reg. Dist. No.

02782

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. LENGTH OF STAY IN 1b <u>4 MO.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3032 DUNLEER RD</u>				d. STREET ADDRESS <u>13032 DUNLEER RD</u>			
3. NAME OF DECEASED (Type or print) First <u>LILLIAN</u> Middle <u>S</u> Last <u>MOORE</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>4</u> Year <u>19 61</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 17-1881</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>W.V.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>W.W. THOMAS</u>				14. MOTHER'S MAIDEN NAME <u>DONT KNOW</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT <u>JOHN T. MOORE SR</u> Address <u>3032 DUNLEER RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>DUE TO</u> (c) <u>24 HRS -</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Aneurysm - 1959</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 28, 1961</u> , to <u>March 4, 1961</u> , that I last saw the deceased alive on <u>March 3, 1961</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M.B. Davis</u> M.D. <u>6800 Morning Ln</u>				ADDRESS (Street, city or town, state) <u>Dundalk - Md</u> DATE SIGNED <u>3/4/61</u>			
PHYSICIAN'S NAME (Type) <u>M.B. DAVIS MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>MAR 4-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SUNNYSIDE CEM</u>		22d. LOCATION (City, town, or county) (State) <u>CHARLSTON W.V.A</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM FUNERAL HOME</u> ADDRESS <u>2112 DUNDALK RD</u>				24a. REC'D BY REGISTRAR <u>MAR 6 1961</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



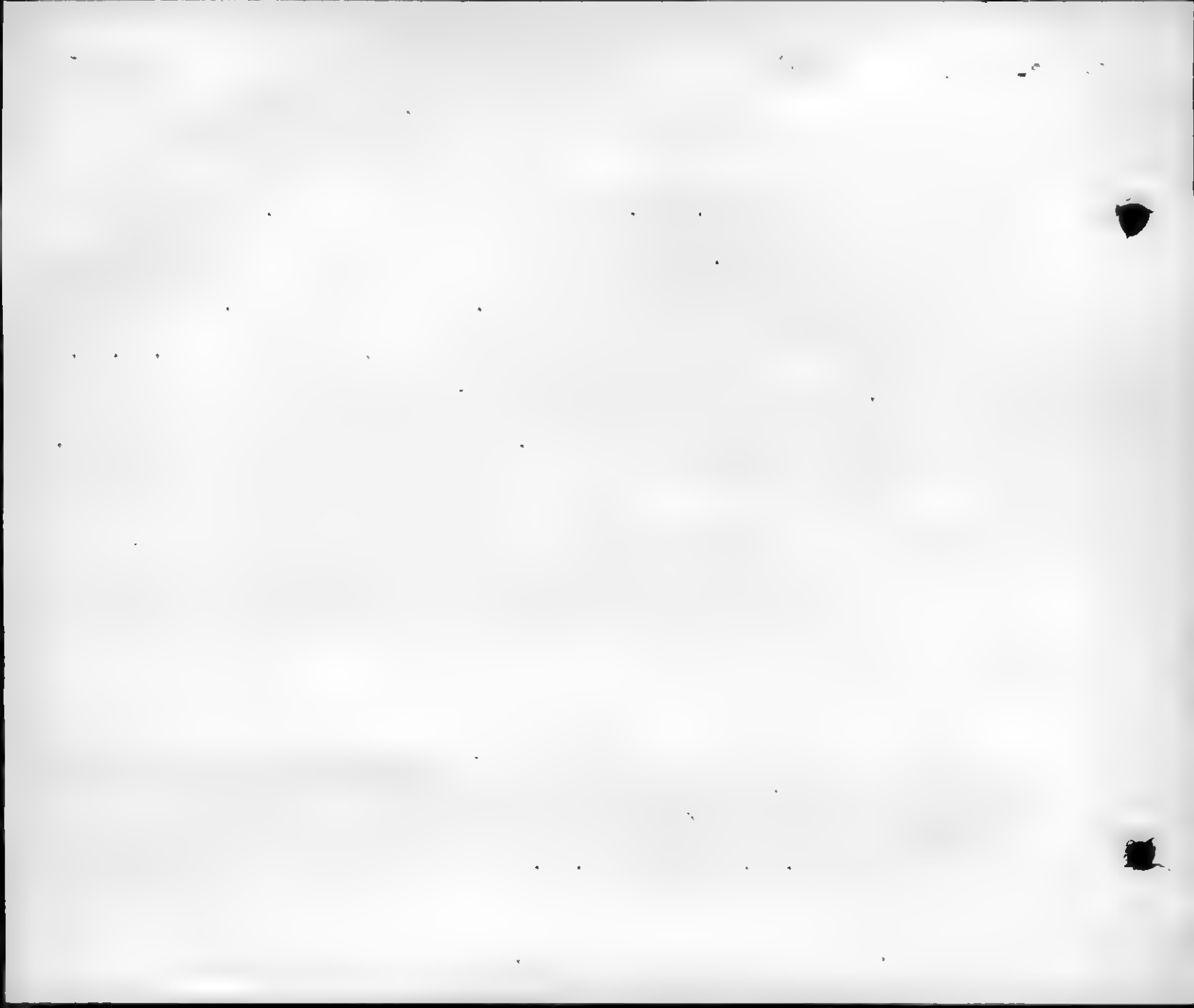
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2801

02783

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b Baltimore d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4312 Highview Ave. #29		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4312 Highview Ave. #29 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mable E. Middle Morgan Last 		4. DATE OF DEATH Month March Day 10 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1885
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY 	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Samuel L. Thomas	
14. MOTHER'S MAIDEN NAME May Carson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Eleanor Herion 4312 Highview Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Decompensation DUE TO Arteriosclerotic Cardio-Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 6 Months 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from OCT 2 1954 to 3/10 1961 , that (I) (we) last saw the deceased alive on 3/9 1961 , and that death occurred on 3/10 1961 AM, from the causes and on the date stated above.			
22a. SIGNATURE James R. Grabill		22b. DATE SIGNED 	
22c. PHYSICIAN'S NAME (Type) James R. Grabill, M. D.		22d. ADDRESS 5550 Baltimore National Pike	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/13/61	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City, town, or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Ave.		25a. REC'D BY REGISTRAR MAR 13 '61 DATE 	25b. REGISTRAR'S SIGNATURE Arthur S. Klaus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G2.2 3/16/61 mh

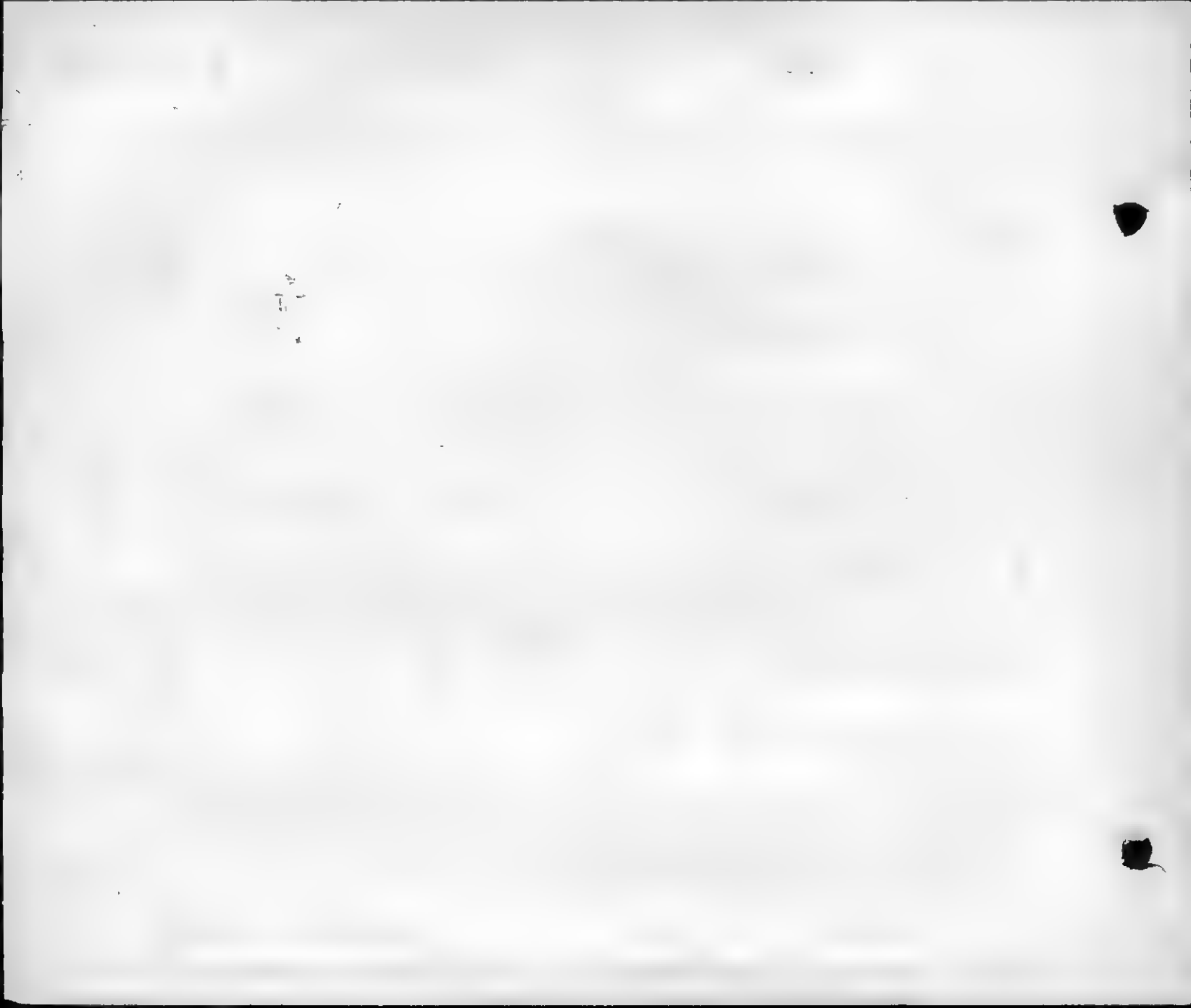
2802

CERTIFICATE OF DEATH

Reg. Dist. No. 02784

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANSDOWNE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANSDOWNE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>216 Clyde Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CATHERINE A. MORRISON</u>				4. DATE OF DEATH Month Day Year <u>MARCH 10, 1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/17/1902</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Richard Nicholson</u>				14. MOTHER'S MAIDEN NAME <u>MARY MILLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MR. Lee MORRISON</u> Address <u>216 Clyde Ave. LANSDOWNE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Breast</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1960</u> , to <u>March 10, 1961</u> , that I last saw the deceased alive on <u>March 7, 1961</u> , and that death occurred at <u>7:54 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3913 Hillcrest Rd. Lansdowne 27 Md</u> DATE SIGNED <u>3/10/61</u> ACTUAL SIGNATURE <u>Man W Steinberg</u> M.D. PHYSICIAN'S NAME (Type) <u>MORRIS N. STEINBERG</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/13/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral CEM. BALTO. Md.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. TRUMAN SCHWAB</u> <u>3512 Frederick Ave. (29)</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be filled in by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2803

CERTIFICATE OF DEATH

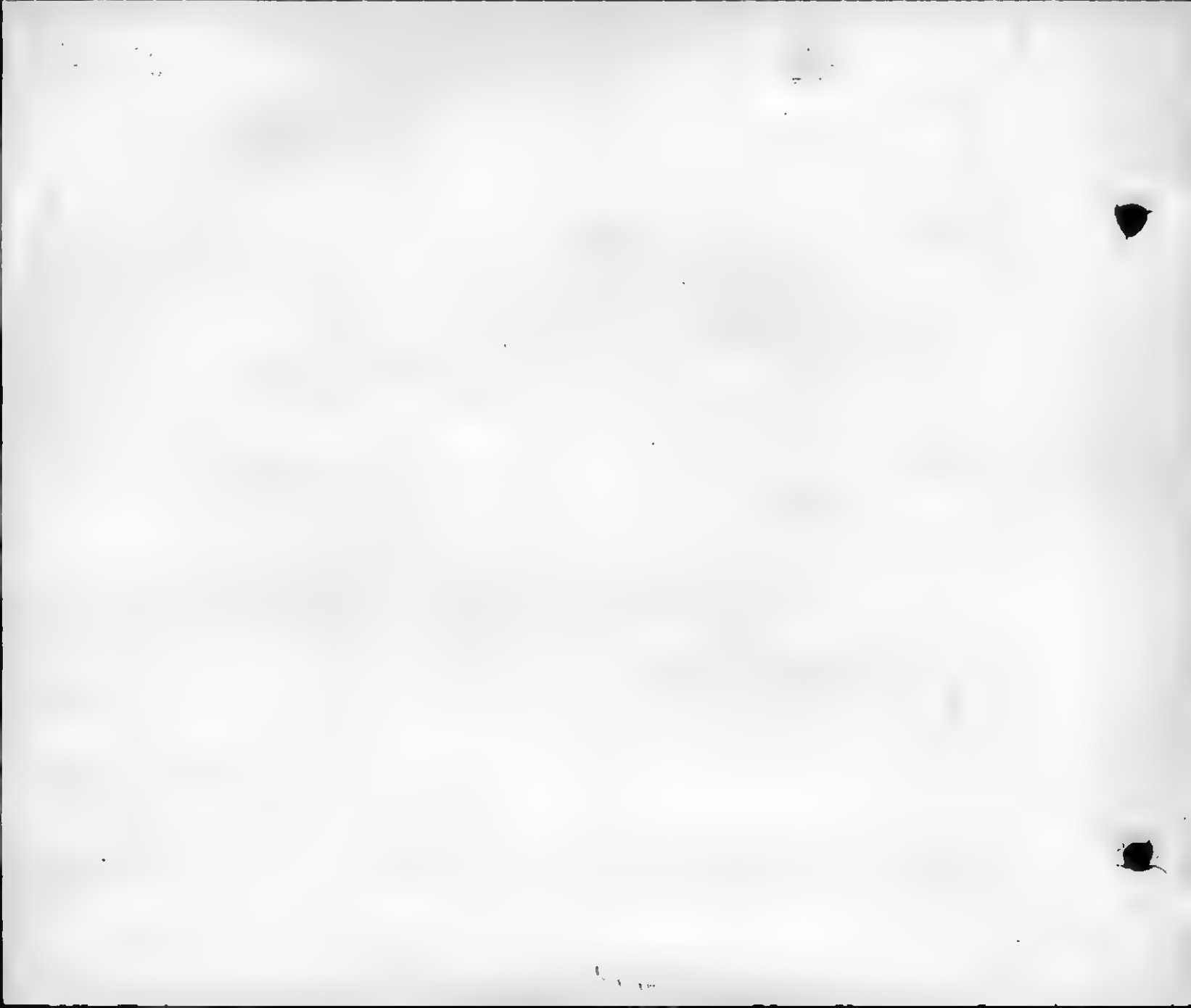
Reg. Dist. No.

02785

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> 19. <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt. area</u>		c. LENGTH OF STAY IN 1b <u>59 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2907 Sparrows Pt. Rd.</u>		d. STREET ADDRESS <u>#1</u>	
3. NAME OF DECEASED (Type or print) <u>FLORENCE IRENE MORRISON</u>		4. DATE OF DEATH <u>Mar. 1. 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14. 1886</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>KING GEORGE, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>KEVIN GREEN</u>		14. MOTHER'S MAIDEN NAME <u>NANNIE RAWLINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>FRANK MORRISON - HUSBAND</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DIS.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>7 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB. 28, 1961</u> to <u>MAR. 1, 1961</u> , that I last saw the deceased alive on <u>FEB. 28, 1961</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis N. Tollin</u>		ADDRESS (Street, city or town and state) <u>6908 NORTH POINT RD.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>LOUIS N. TOLLIN</u>		<u>BALTIMORE-19-MD. MAR. 1. 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-4-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MOUNT CARMEL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u>		ADDRESS <u>418 East 3rd St.</u>	
24a. REC'D BY REGISTRAR <u>MAR 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

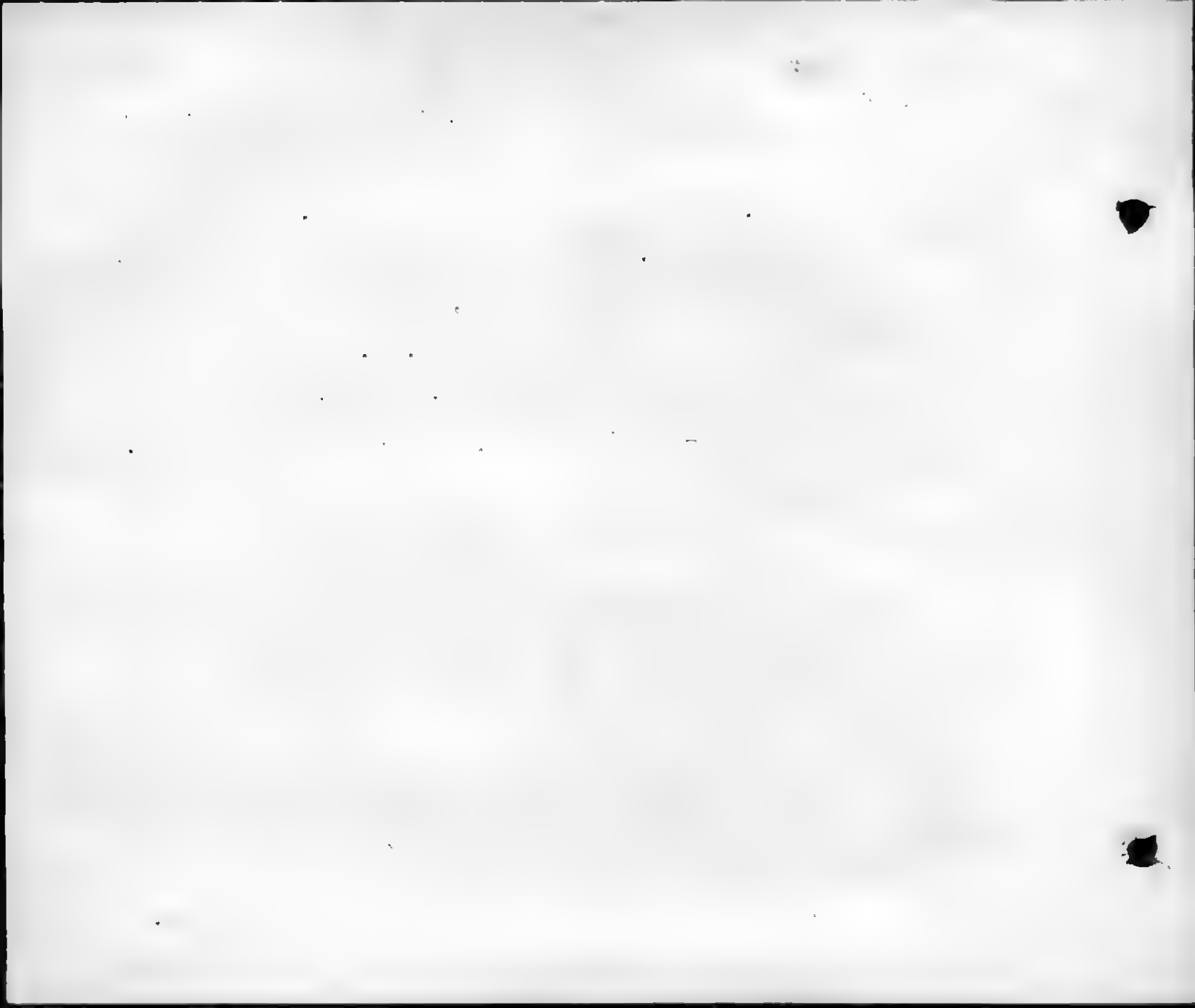
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2804

02786

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 Elmont Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle H. Last Mueller				4. DATE OF DEATH Month March Day 22 Year 1961			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 19, 1875	9 AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electiracl		11 BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME Jacob Mueller				14. MOTHER'S MAIDEN NAME Christina Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO. 219-14-1822		17. INFORMANT Address Louis C. Mueller 3103 1/2 Willoughby Rd. 14			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart disease DUE TO (c) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 48 hours 2 mos (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1961 to Mar 22, 1961 , that (I) (we) last saw the deceased alive on Mar. 21, 1961 , and that death occurred at 11 A.M. from the causes and on the date stated above							
22a. SIGNATURE James T. Means				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) James T. Means				22d. ADDRESS 520 D St. Balto. 15 Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-25-1961		23c. NAME OF CEMETERY OR CREMATORY Baltimore		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lassakin Funeral Home				ADDRESS 7401 Belair Rd.		25a. REC'D BY REGISTRAR DATE MAR 24 '61	
				25b. REGISTRAR'S SIGNATURE William S. Hume			



may be filled by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02787

2805

CERTIFICATE OF DEATH

Former - 260 N. Kilton St
Reg. Dist. No.

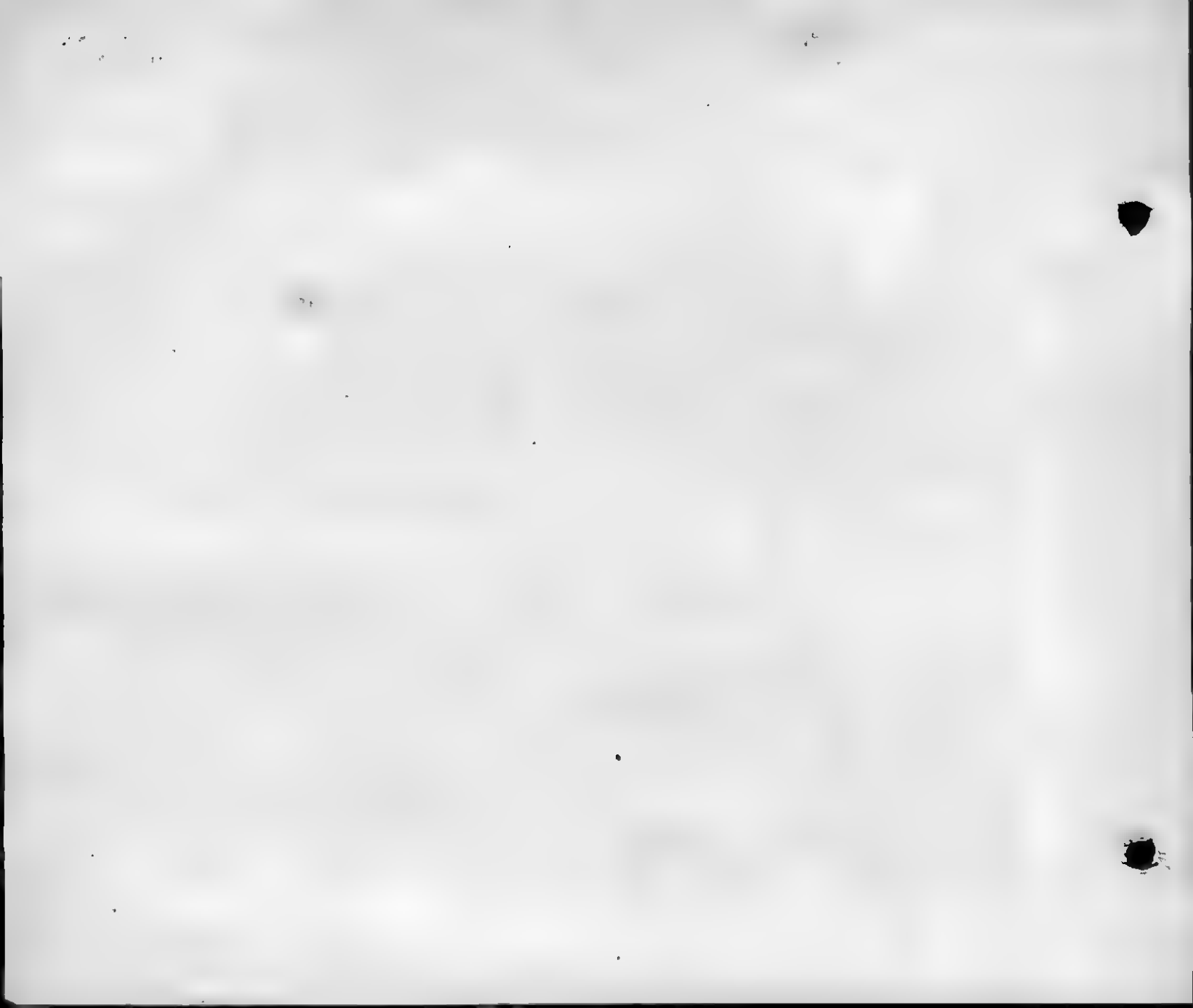
1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN lb <u>9 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Angelsburg Lutheran Home</u>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Co. Md.</u> d. STREET ADDRESS <u>6811 Hampfield Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AMELIA</u> Middle <u>CATHERINE</u> Last <u>MUHL</u>		4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 71</u>
9 AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sever</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Herman Muhl</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Bauer</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>D. W. Katorkamp 6815 Hampfield</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CM - Carcinoma of Bladder</u> DUE TO (b) <u>2) Arterio Sclerotic Heart Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>3 years</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio Sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/25</u> , 19 <u>60</u> , to <u>March 21</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 20</u> , 19 <u>61</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl L. Chambers</u>		ADDRESS (Street, city or town, state) <u>4108 Liberty Hts Balto Md</u> DATE SIGNED <u>3-21-61</u>	
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>		<u>4108 Liberty Hts Balto Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/24/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Immanuel</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.A. Heemann</u> ADDRESS <u>6067 Harford Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 28 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>



TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MAYLAND STATE DEPARTMENT OF HEALTH											
Division of MEDICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 18, Film G-203 3724761.rr Item 18, Film G-203 3724761.rr 02788											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived, if institution, Res. date before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Upperco</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>225 Willow Ave</u>				d. STREET ADDRESS <u>Emory Church Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George C. Myers</u>				4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1961</u>							
5. SEX <u>M</u>				6. COLOR OR RACE <u>Wh</u>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>August 20, 1941</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maryland State Police</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>				9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Birth day) Months Days Hours Min. <u>19</u> yrs. <u>19</u> months <u>19</u> days <u>19</u> hours <u>19</u> min.			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Marvin Myers</u>				14. MOTHER'S MAIDEN NAME <u>Grace Hoffman</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-40-5923</u>				17. INFORMANT <u>Mr. Marvin Myers, Upperco, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular dis.</u> Conditions, if any, which gave rise to immediate cause (b) <u>43X</u> (a), stating the underlying cause last. (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DUE TO</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>W. Bradley King Jr</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>Mar. 5, 1961</u>			
EXAMINER'S NAME (Type) <u>W. Bradley King Jr</u>				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>March 8, 1961</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Emory Church Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Carroll Md.</u>											
23. FUNERAL DIRECTOR <u>J.F. Eline & Sons, Reisterstown, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 9 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

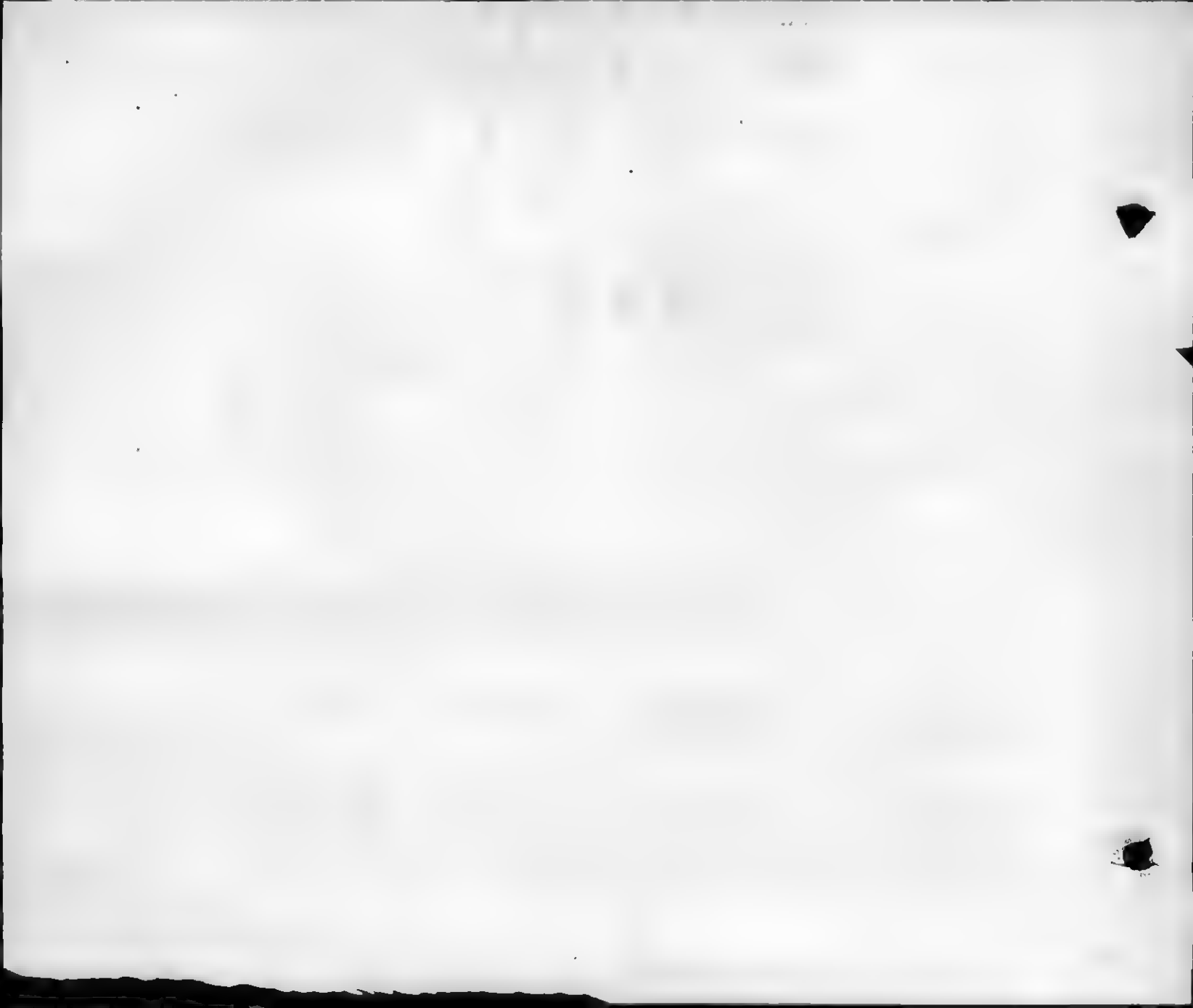
Reg. Dist. No.

02789

2807

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KINGSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X KINGSVILLE MD.</u>			
c. LENGTH OF STAY IN 1b <u>20 YRS.</u>				d. STREET ADDRESS <u>Box 667</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 667 KINGSVILLE MD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Glady's</u> Middle <u>M</u> Last <u>Neal</u>				4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29, 1910</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Eval Harber</u>				14. MOTHER'S MAIDEN NAME <u>Hohn Lula Bowden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>236-34-0897</u>		17. INFORMANT <u>John Neal</u> Address <u>Box 667 Kingsville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer left Adrenal</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan.</u> , 19 <u>56</u> , to <u>March</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 24, 1961</u> , and that death occurred at <u>5:30</u> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>William A. Tyson</u> M.D. <u>Kingsville, Md.</u> <u>3-25-61</u> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/28/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREEN HILL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WAYNESBORO, PENN.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassala Funeral Home</u>				ADDRESS <u>7401 Belair Rd #6 Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 29 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. L. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2808

CERTIFICATE OF DEATH

02790

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN <u>MD</u> <u>6 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1603 Presbury Street (17)</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>THOMAS W. NELSON</u> First Middle Last				4. DATE OF DEATH <u>March 20 19 61</u> Day Month Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>February 3, 1892</u>		9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		10. C. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Ellicott City, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Thomas Nelson</u>				14. MOTHER'S MAIDEN NAME <u>Cora Barnes</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>218-05-5143</u>			
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ACUTE PANCREATIC NECROSIS- RECENT</u>							
18. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18) _____							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		20g. (County) _____		20h. (State) _____			
21. I certify that (If (x) (this hospital) attended the deceased from <u>March 14 1961</u> , to <u>March 20 1961</u> , that (H) (we) last saw the deceased alive on <u>March 20 1961</u> , and that death occurred at <u>A.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas F. Crahan</u> NAME (Type) <u>THOMAS F. CRAHAN, M.D.</u>				22b. DATE SIGNED <u>3/20/61</u>			
22c. PHYSICIAN'S ADDRESS <u>VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.</u>				22d. ADDRESS _____			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/23/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>			
23d. LOCATION (City, town or county) <u>Baltimore 28, Maryland</u>		23e. (State) _____					
24. FUNERAL DIRECTOR'S SIGNATURE <u>George G. Kelson</u>				25a. REC'D BY REGISTRAR <u>MAR 23 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>				25c. ADDRESS <u>1348 N. Calhoun St. Baltimore 17, Md.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed in by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



2809

CERTIFICATE OF DEATH

Reg. Dist. No. 02791

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 9yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Barrymans Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maggie Middle Odella Last Nolte		4. DATE OF DEATH Month March Day 5 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 7, 1871
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 89 Days 19 Hours 19 Min 19	11. IF UNDER 24 HRS. Hours 19 Min 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John T. Fowble		14. MOTHER'S MAIDEN NAME Eliza Gill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ivan G. Nolte, Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Hypertension + arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of stomach			
INTERVAL BETWEEN ONSET AND DEATH 2 days year			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m 19 p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-30 to 3-5-61 , 19 61 , that I last saw the deceased alive on 3-5-61 and that death occurred at 6 P M , from the causes and on the date stated above			
ACTUAL SIGNATURE James G. Saffell M.D.		ADDRESS (Street, city or town, state) Reisterstown, Md	
PHYSICIAN'S NAME (Type) James G. Saffell		DATE SIGNED 3-6-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 8, 1961	
22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove		22d. LOCATION (City, town, or county) (State) Boring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE MAR 9 '61	
		24b. REGISTRAR'S SIGNATURE Orlino S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2810

CERTIFICATE OF DEATH

Reg. Dist. No. 02792

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Baltimore</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7631 Daniels Ave.</u>		d. STREET ADDRESS <u>17631 Daniels Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Novotny</u> Last <u></u>		4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16 1877</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	IF UNDER 24 HRS Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Frank Hrnicka</u>	
14. MOTHER'S MAIDEN NAME <u>Josephine Zika</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Charles J. Kozlosky, 7631 Daniels Ave., Zone 14.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Failure</u> DUE TO <u>Coronary Thrombosis</u> DUE TO <u>Arteriosclerosis Generalized</u> DUE TO <u>Renal Sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 dys.</u> <u>8 dys.</u> <u>10 dys.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day Year Hour <u></u> a.m. <u></u> p.m. <u></u> 19 <u></u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 17 1961</u> to <u>Mar 26 1961</u> , that I last saw the deceased alive on <u>Apr 25 1961</u> , and that death occurred at <u>8:45</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasik, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>9805 HARFORD RD. BALTO 14, Md.</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK JR</u>		DATE SIGNED <u>3/26/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 29, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank K. Cusack & Son</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 27 '61</u>	
ADDRESS <u>900 N. Chestnut St.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2811 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film G284 4/7/61 iwk

Reg. Dist. No.

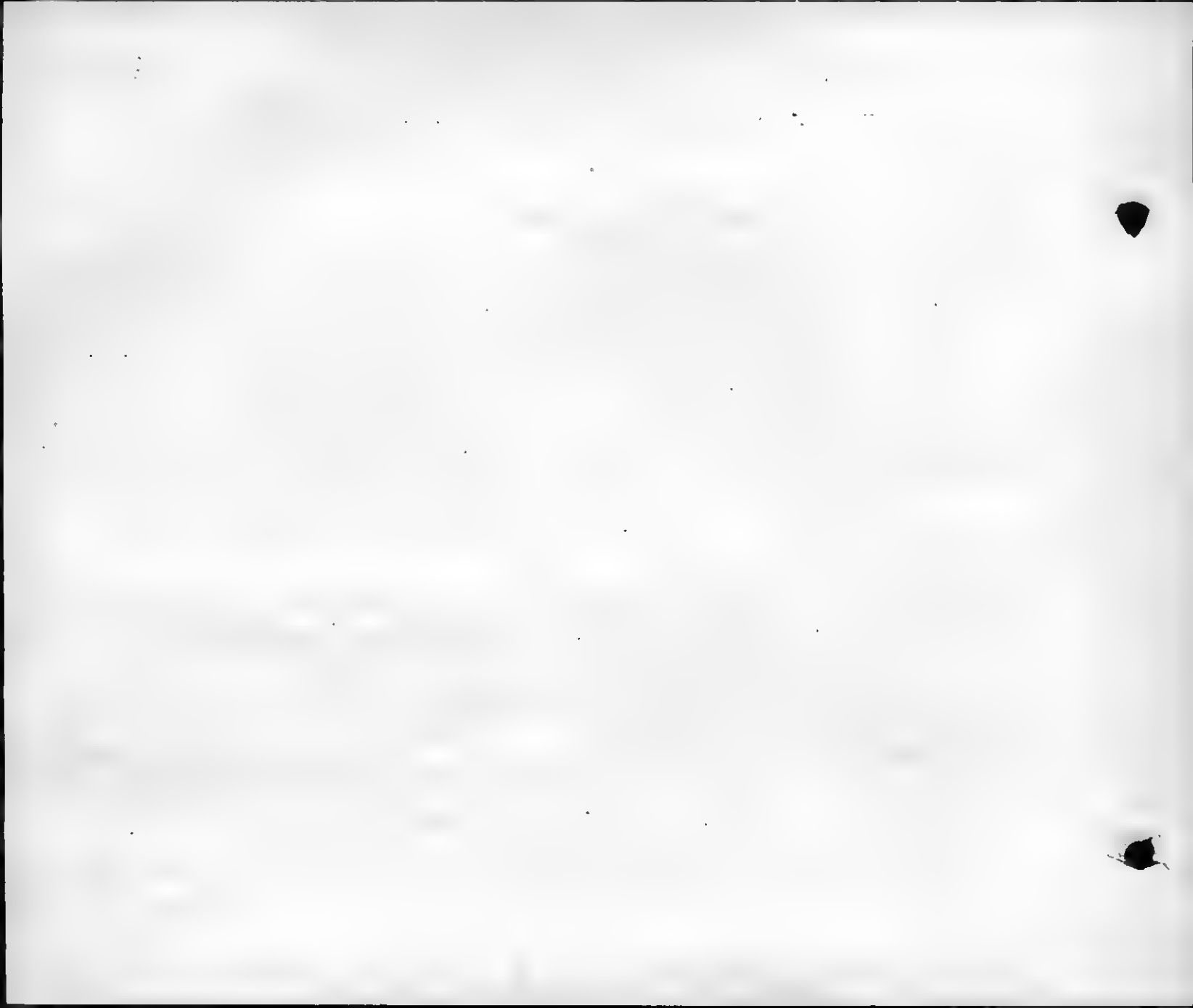
02793

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3110 Yorkway</u>				d. STREET ADDRESS <u>3110 Yorkway</u>			
3. NAME OF DECEASED (Type or print) <u>Sohn Elmer Parker</u>				4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1894 Jan 16 1893</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brewery</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Jefferson Parker</u>				14. MOTHER'S MAIDEN NAME <u>Mary Clinton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-03-7434</u>		17. INFORMANT <u>Teresa Parker</u> Address <u>3110 Yorkway</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> DUE TO <u>Arteriosclerotic Heart dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic duodenal ulcer</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack E Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JACK E COLLINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 28/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ulrich Funeral Home</u>				ADDRESS <u>2112 Dundalk</u>		24a. REC'D BY REGISTRAR <u>AR 28 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please effectuate it by certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





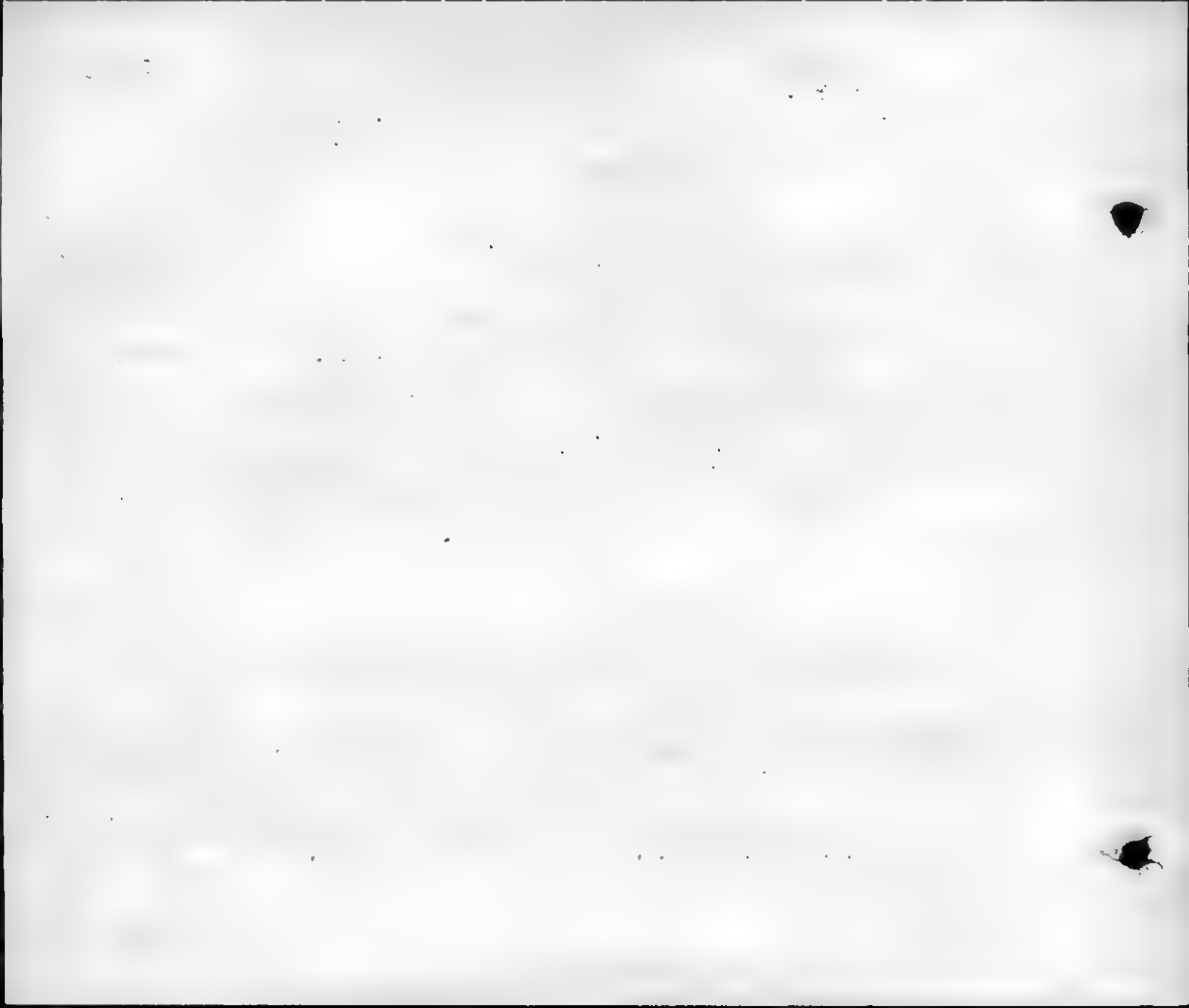
(M)

2813

MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02795

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balto</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Monkton</i>				c. LENGTH OF STAY IN 1b <i>5 yrs.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <i>1</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <i>WILLIAM - BLAINE - PHILLIPS</i>				4. DATE OF DEATH Month Day Year <i>May 7 1961</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-22-1885</i>	9. AGE (In years last birthday) <i>76</i> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>W Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph W Phillips</i>				14. MOTHER'S MAIDEN NAME <i>Alice Melson</i>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>219-16-2498</i>		17. INFORMANT <i>Mr Paul Dawson - Eccumount Md</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO (b) <i>Arterio-sclerotic C-V Disease</i> DUE TO (c) <i>5 yrs.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <i>16 mo</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 12 to March 29, 1961</i> , that (I) (we) last saw the deceased alive on <i>3-28-61</i> , and that death occurred at <i>4 M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>M. C. Porterfield</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>3-29-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>M. C. Porterfield, M.D.</i>				22d. ADDRESS <i>Hampstead, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-1-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greenmount</i>		23d. LOCATION (City, town, or county) (State) <i>Charles Co Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Edw Epton</i>				25a. REC'D BY REGISTRAR <i>3 '61</i>		25b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

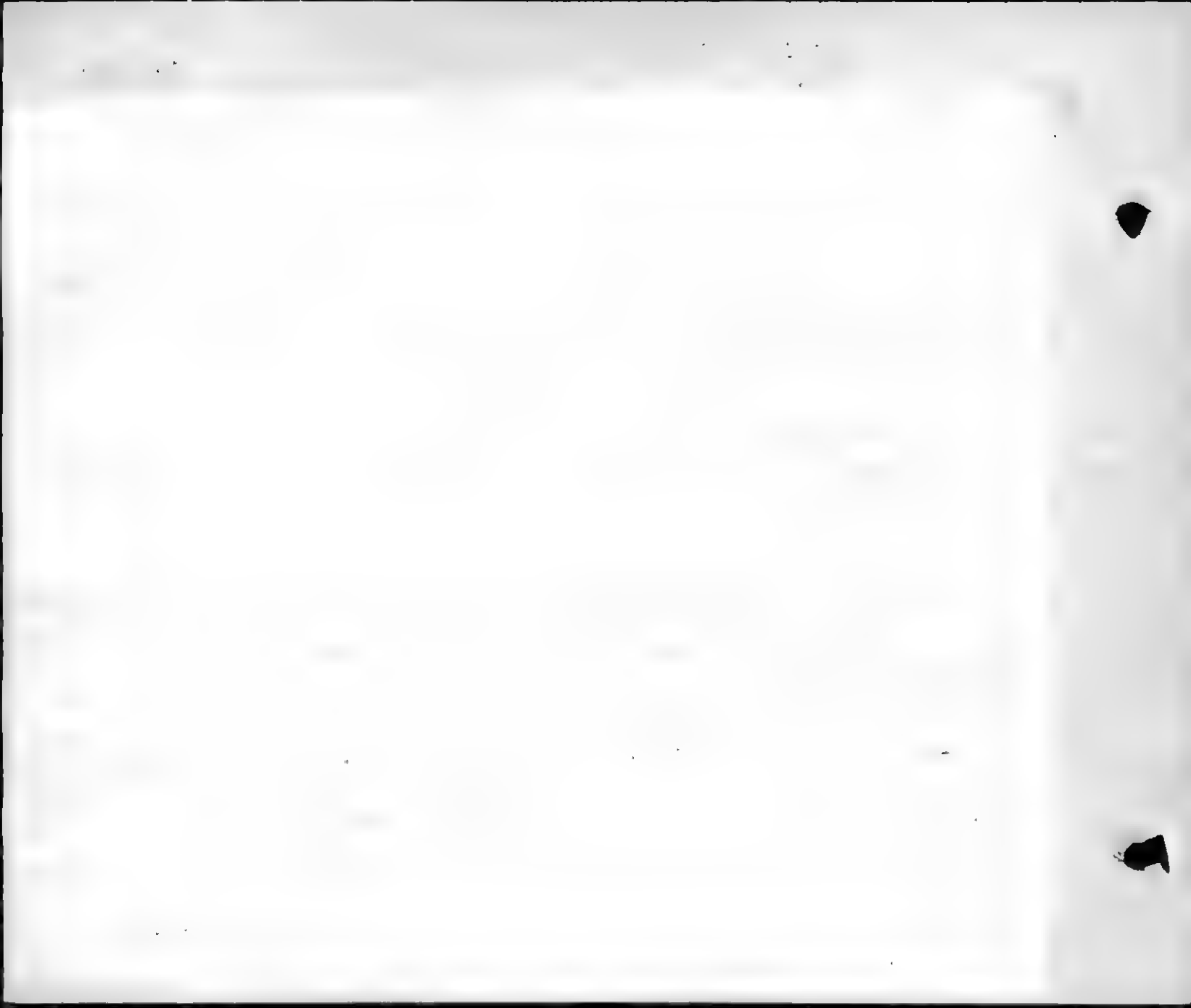
2814

02796

1. NAME OF DECEASED (Type or Print) <u>MARY PUCETA</u>		2. DATE OF DEATH <u>MARCH - 1 - 1961</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore County</u> (If not in hospital or institution, give street address or location) <u>HOUSE IN THE PINES</u> <u>16 FUSTING AVE</u>		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> (If outside city limits, write RURAL and give township) <u>29</u> D. STREET ADDRESS (If rural, give location) <u>1008 Beechfield Ave.</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>MAY 15 - 1884</u>
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>LITHUANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-18-5176-D</u>	
17. INFORMANT <u>Records</u>		ADDRESS	
18. CAUSE OF DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) <u>Cerebral Hemorrhage</u> DUE TO (B) <u>hypertension with arteriosclerosis</u> DUE TO (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>10; 31</u>	
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19a. DATE OF OPERATION _____	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from <u>1-28-1961</u> to <u>3-1-1961</u> that (I) (we) last saw the deceased alive on <u>3-1-1961</u> and that in (my) (our) opinion death occurred at <u>3:05 p.m.</u> from the causes and on the date stated above.			
23a. SIGNATURE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> <u>Frederick K. Gallagher</u> M.D.		23b. ADDRESS <u>6229 Frederick St. Balt. 28</u>	
23c. DATE SIGNED <u>3-2-61</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>3-4-1961</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer</u>	
24d. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>Maryland</u>		25a. FUNERAL DIRECTOR <u>Charles W. Sackowich</u>	
25b. DATE REC'D BY HEALTH DEPT <u>MAR 6 '61</u>		25c. NAME OF REGISTRAR <u>Arthur S. Kinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

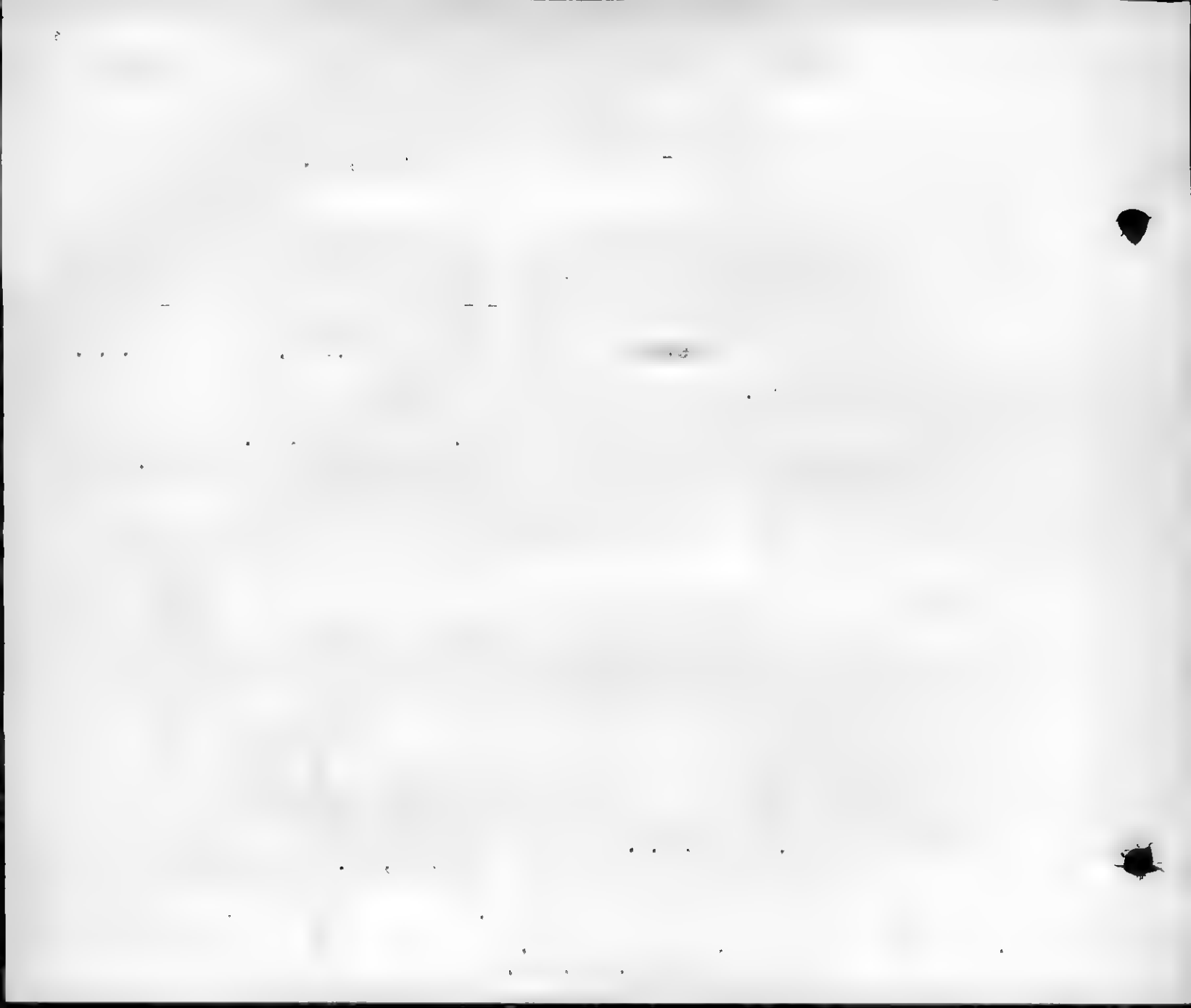
VR A15 (4)
15M 9/59

2815

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02797

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE 8 Bishop Road b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay				c. LENGTH OF STAY IN 1b 9-28-'55			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Relay Hill Hospital				d. STREET ADDRESS Baltimore 18, Md.			
3. NAME OF DECEASED (Type or print) First Frederick Middle Brune Last Randall				4. DATE OF DEATH Month March Day 4 Year '61			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-3-1885	
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 3 Days - Hours - Min -		11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.	
13. FATHER'S NAME Blanchard Randall Sr.				14. MOTHER'S MAIDEN NAME Susin Brune			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (if yes, give war or dates of service) no				16. SOCIAL SECURITY NO. Sister: Mrs. Bessie Slack, Jr.			
17. INFORMANT 8 Bishop Road, Baltimore 18, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 20-1 Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Many years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month March Day 4 Year 1961 Hour 8 a. m. PM				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State) March			
21. I certify that (I) (this hospital) attended the deceased from Sept 28, 1955 to Oct 4, 1961 , that (I) (we) last saw the deceased alive on Oct 4, 1961 , and that death occurred at 8 AM , from the causes and on the date stated above							
22a. SIGNATURE Lewis P. Gundry				22b. DATE SIGNED March 4, 1961			
22c. PHYSICIAN'S NAME (Type) Lewis P. Gundry, M.D.				22d. ADDRESS Relay, 27, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/6/1961		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co.				25a. REC'D BY REGISTRAR DATE MAR 8 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	
ADDRESS 4905 York Rd. Balto. 12, Md.							



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2816

CERTIFICATE OF DEATH

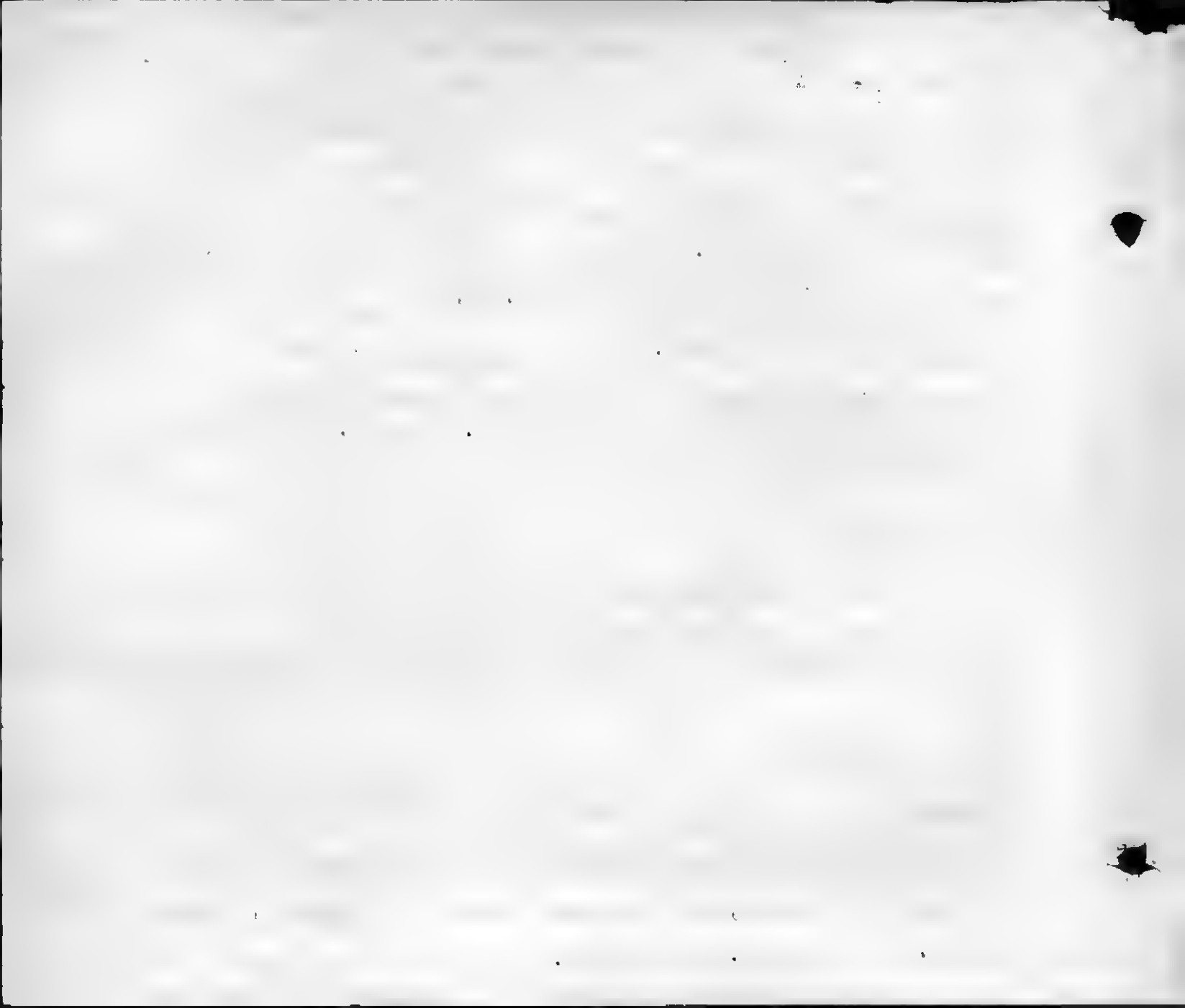
Reg. Dist. No.

02798

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>app 2 yrs</u>		d. STREET ADDRESS <u>13528 McShane Way</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3528 McShane Way</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annetta M. Regan</u>		4. DATE OF DEATH Month Day Year <u>March 25, 1961</u> 19 <u>61</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16, 1884</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Marcellus Rogers</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ahern</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO <u>yes</u>	
17. INFORMANT <u>Joseph M. Regan Jr.</u>		Address <u>3528 McShane Way</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE - HEMIPLEGIA</u> <u>422.1</u> DUE TO <u>ARTERIOSCLEROTIC CARDIOVASCULAR DLS.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/30/53</u> to <u>3/25</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>3/24</u> , 19 <u>61</u> , and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Benjamin H. Hluthstein</u> M.D.		ADDRESS (Street, city or town, state) <u>121 S. HILTHARD AVE BALTIMORE, MD.</u>	
DATE SIGNED <u>3/24/61</u>			
PHYSICIAN'S NAME (Type) <u>DR. BENJAMIN HLUTHSTEIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 28, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u>		ADDRESS <u>3000 E. Baltimore St.</u>	
24a. REC'D BY REGISTRAR <u>MAR 29 '61</u>		24b. REGISTRAR'S SIGNATURE <u>J. L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2817

Items 13 U. FILM G292 3/11/61 mh

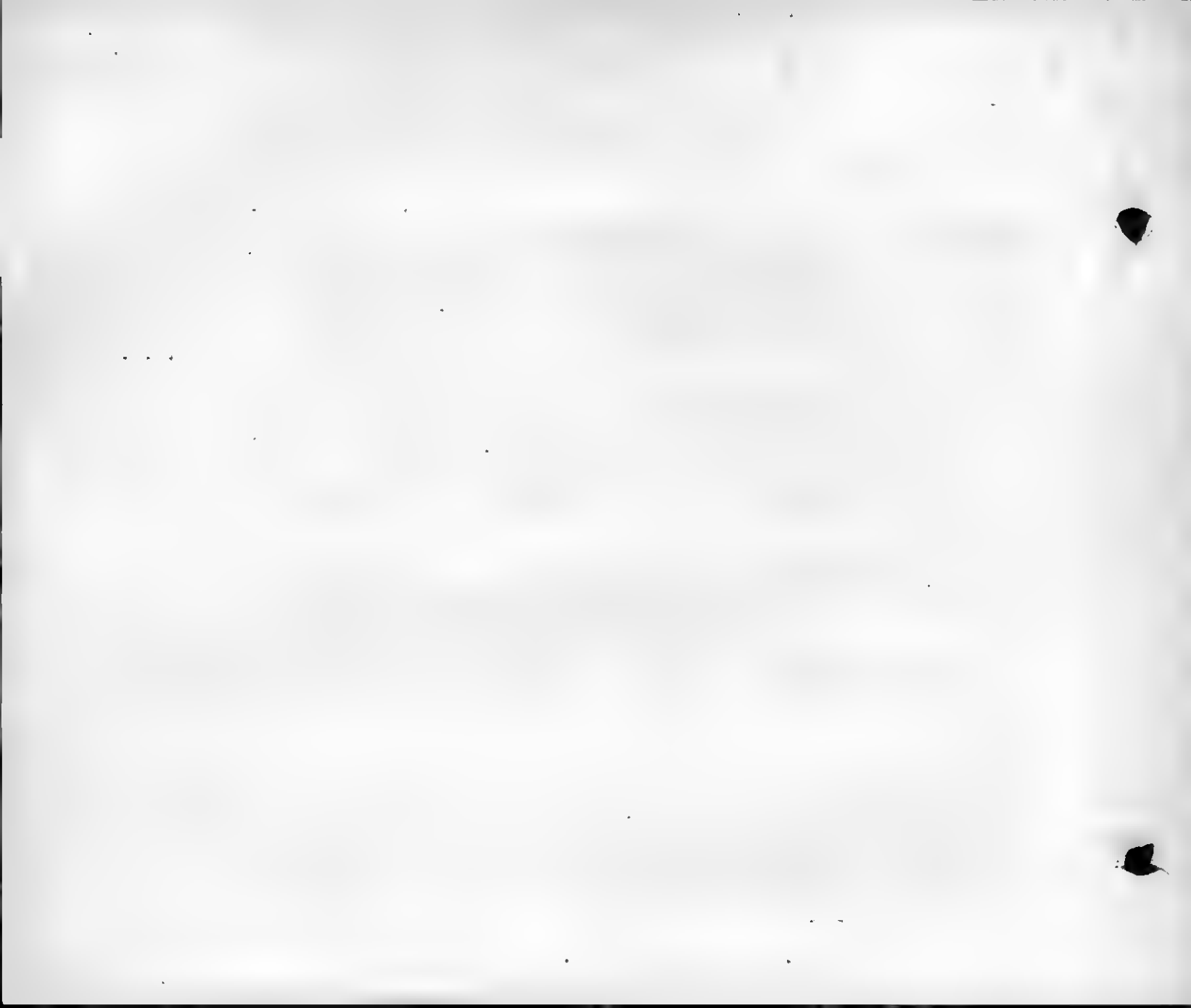
CERTIFICATE OF DEATH

Reg. Dist. No. 02799

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home		d. STREET ADDRESS 634 S. Linwood Ave.	
3. NAME OF DECEASED (Type or print) FREIDA (FORTUNATA) REINA		4. DATE OF DEATH Month March Day 4 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1883
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown - (Born and died in Italy)	
14. MOTHER'S MAIDEN NAME Unknown - (Born and died in Italy)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Frank B. Reina 2800 Dillion Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 191X DUE TO Acute & Chronic Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Pneumonia Bronchial Bilet. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemiplegia Left side 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 59 3/4/61	
21. I certify that I attended the deceased from 3/3/61 19 30 A to 3/4/61 19 30 A , that I lost saw the deceased alive on 3/3/61 19 30 A , and that death occurred of 30 A M, from the causes and on the date stated above		ADDRESS (Street, city or town, state) DATE SIGNED 1303 Frederick Rd Catonsville 28 md 3/6/61	
ACTUAL SIGNATURE W. E. McGrath		M.D.	
PHYSICIAN'S NAME (Type) W. E. McGrath		Catonsville 28 md 3/6/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-8-1961	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	22d. LOCATION (City town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc. 1901 Eastern Ave.		ADDRESS	
24a. REC'D BY REGISTRAR DATE MAR 8 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2818

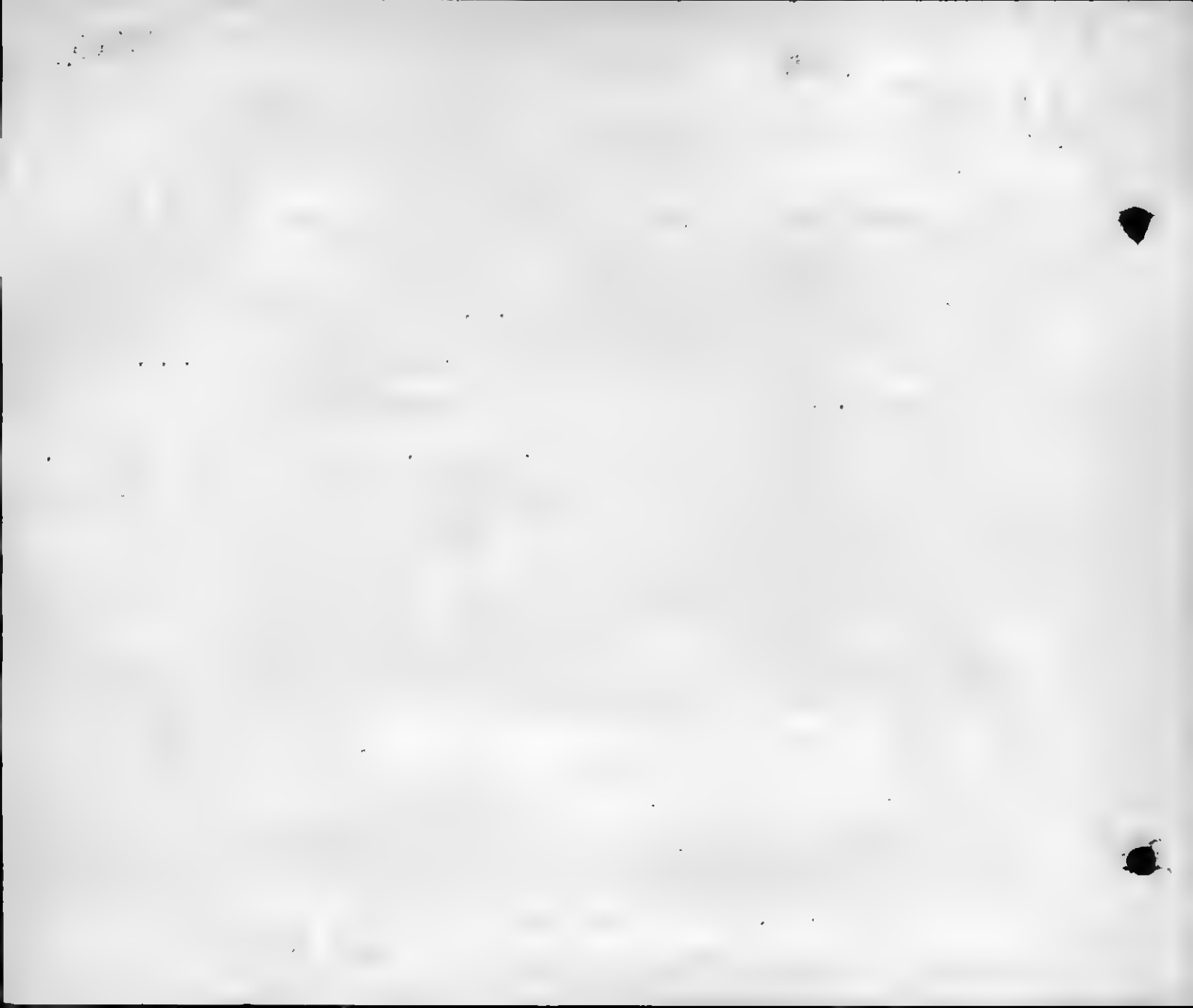
CERTIFICATE OF DEATH

02800

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Catonsville Summit Nursing Home		d. STREET ADDRESS 4314 Cedar Garden Road	
3. NAME OF DECEASED (Type or print) Mary Estelle Rew		4. DATE DEATH March 4, 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 6, 1893	
9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 67 yrs. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thaddeus C. Hobbs	
14. MOTHER'S MAIDEN NAME Elizabeth Peebles		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Edward L. Lockner-4314 Cedar Garden Rd.	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast 70X DUE TO Conditions, if any, which gave rise to immediate cause (b) — (a), stating the underlying cause last. (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (i) (this hospital) attended the deceased from 2-11-1961 to 3-4-1961, that (i) (we) last saw the deceased alive on 3-2-1961, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE George M. Ramapuram		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) George M. Ramapuram		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 3502 Croydon Rd, Baltimore 7, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 8, 1961	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE H. J. Lockner & Sons North & Anna Balto, Md		25a. REC'D BY REGISTRAR DATE MAR 8 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

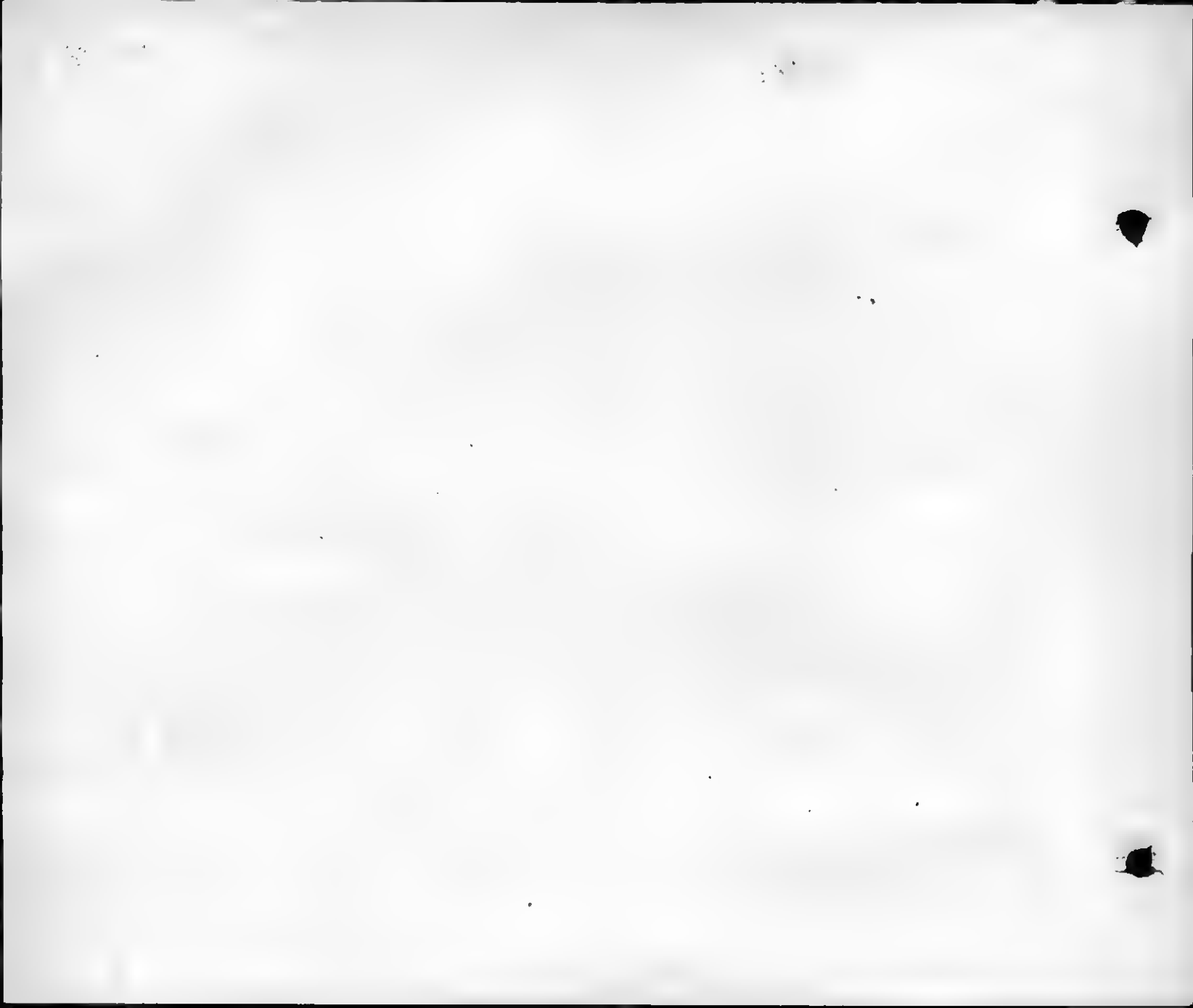
VR A15 (4)
15M 9/59

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2819
CERTIFICATE OF DEATH

02801

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale c. LENGTH OF STAY IN 1b X d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2106 Summit Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rosedale d. STREET ADDRESS 2106 Summit Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HAZEL M. RICHTER		4. DATE OF DEATH Month March Day 15 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1927
9. AGE (In years last birthday) 33 yrs.		10. IF UNDER 1 YEAR Months 3 Days 15 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Armstrong		14. MOTHER'S MAIDEN NAME Don't know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. Julius B. Richter 2106 Summit Ave-6	
17. INFORMANT Julius B. Richter 2106 Summit Ave-6		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Interference to heart DUE TO (c) Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 17 20 19 to MARCH 15, 1961 that (i) (we) last saw the deceased alive on MARCH 15, 1961 , and that death occurred at 1 P.M. from the causes and on the date stated above.			
19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 17 20 19 to MARCH 15, 1961 that (i) (we) last saw the deceased alive on MARCH 15, 1961 , and that death occurred at 1 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Edward P. Davis		22b. DATE SIGNED 15 MAR 1961	
22c. PHYSICIAN'S NAME (Type) Edward P. Davis		22d. ADDRESS 5317 BELAIR RD BALTIMORE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 18, 61	
23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens		23d. LOCATION (City, town, or county) (State) Belair, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.		25a. REC'D BY REGISTRAR DATE MAR 20 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2820

CERTIFICATE OF DEATH

02802

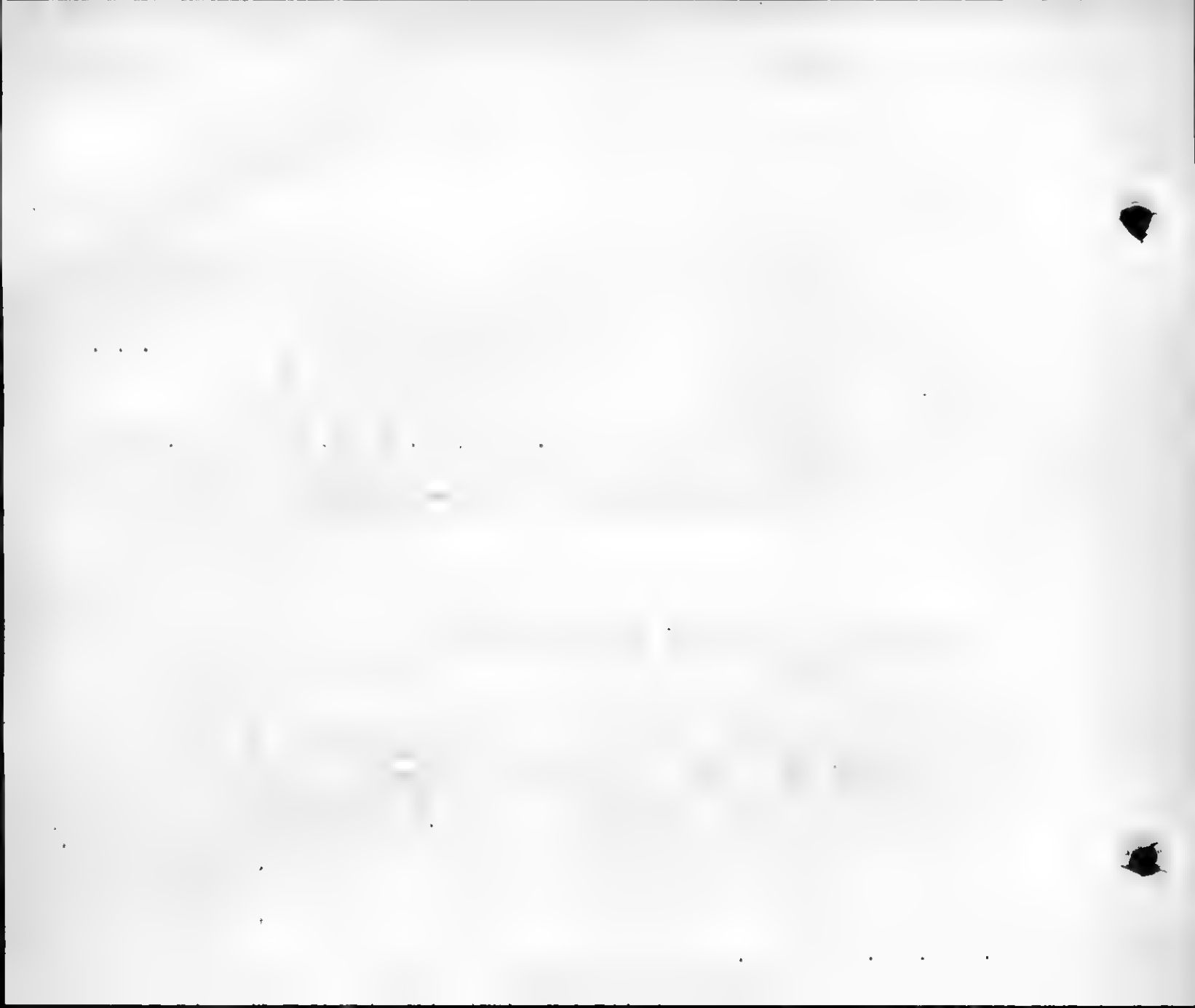
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>4 yr.. 8 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rosanna</u> Middle <u>Griffith</u> Last <u>Ridenour</u>				4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>19 61</u>			
5 SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-16-75</u>	
9 AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Charles Griffith</u>				14. MOTHER'S MAIDEN NAME <u>Rosanna Brism</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>unknown</u>		17 INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gangrenous urinary cystitis with calculus of bladder</u>							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 17, 1961</u> to <u>March 31, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 31, 1961</u> , and that death occurred at <u>2:45</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Aristides Simopoulos</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>3-31-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Aristides Simopoulos, M. D.</u>				22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>4/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>John S. Cook</u>	



CERTIFICATE OF DEATH

Reg. Dist. 02803

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>48 N. Meigs Ave</i> c. LENGTH OF STAY IN 1b <i>2 mo</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>ACORN ME 11 & MEN. HOSP</i>		2. USUAL RESIDENCE (Where deceased lived If institution Res. dence before admission) a. STATE <i>MD</i> b. COUNTY <i>1123 N. EUTAW ST</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> d. STREET ADDRESS <i>1123 N. EUTAW ST</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Ethel</i> Middle <i>BANKS</i> Last <i>RIGGS</i>		4. DATE OF DEATH Month <i>March</i> Day <i>24</i> Year <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 22 1889</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Comp. Mgr - Harsh</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Howard County</i>
13. FATHER'S NAME <i>Samuel Banks</i>		14. MOTHER'S MAIDEN NAME <i>Amanda P. Picum</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>-</i>	
INFORMANT Address <i>Mr. George W. Banks, Sykesville, Maryland</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>174X Carcinoma Uterus, bladder metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>DUE TO</i> (c) <i>DUE TO</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertensive Cardio-Vascular Disease</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>1950</i> to <i>March 24, 1961</i> , that I last saw the deceased alive on <i>March 23, 1961</i> , and that death occurred at <i>12:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Newland Edward Day</i>		ADDRESS (Street, city or town, state) <i>4-E-33rd St Baltimore 18 Md</i> DATE SIGNED <i>March 24 1961</i>	
PHYSICIAN'S NAME (Type) <i>Newland Edward Day</i>		4 East 33rd Street, Baltimore 18	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>3-27-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Oak Grove Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Glenwood, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Wm. C. Ok, Inc., 1217 St. Paul Street</i>		24a. REC'D BY REGISTRAR <i>MAR 27 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the [] Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

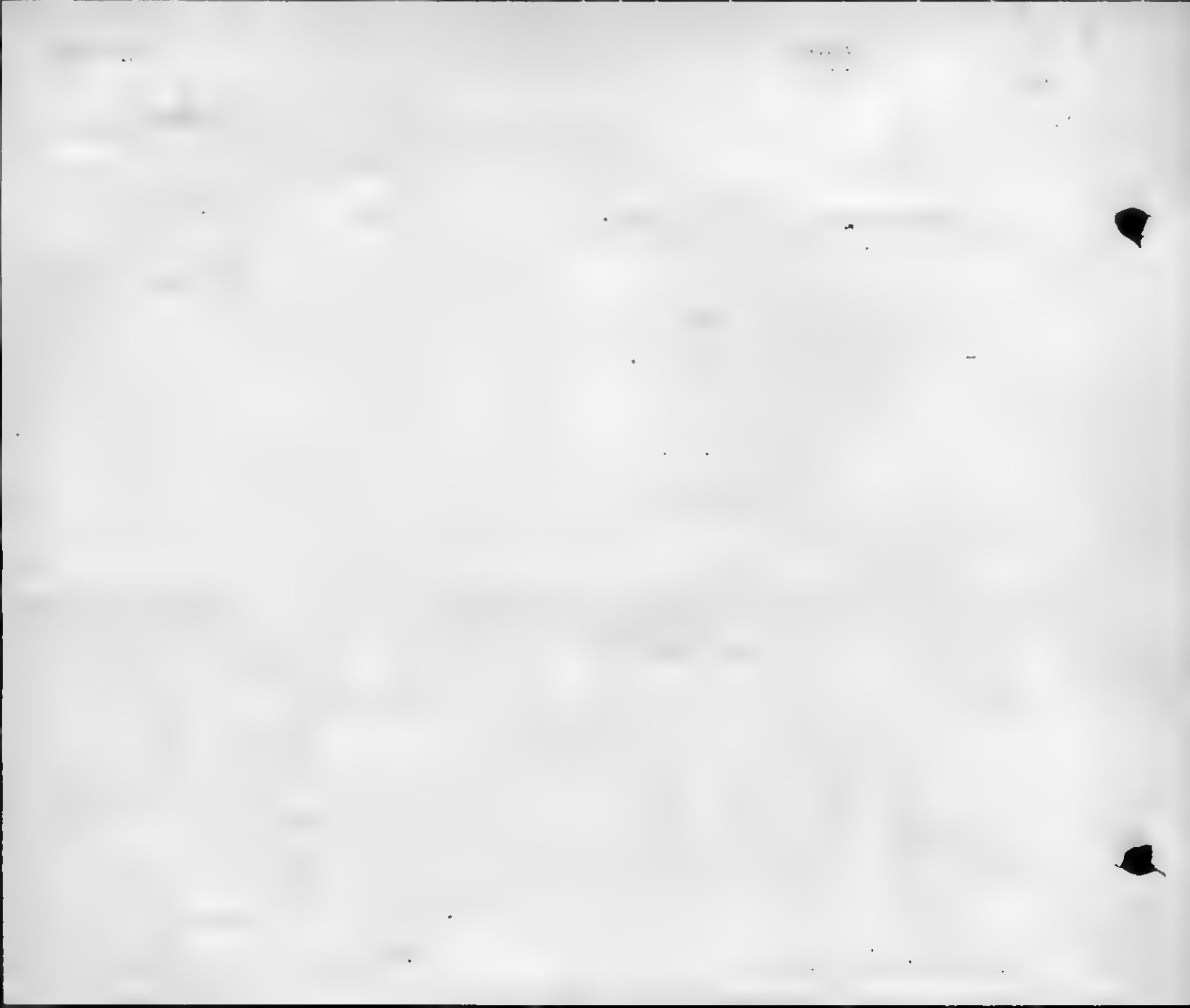
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2822

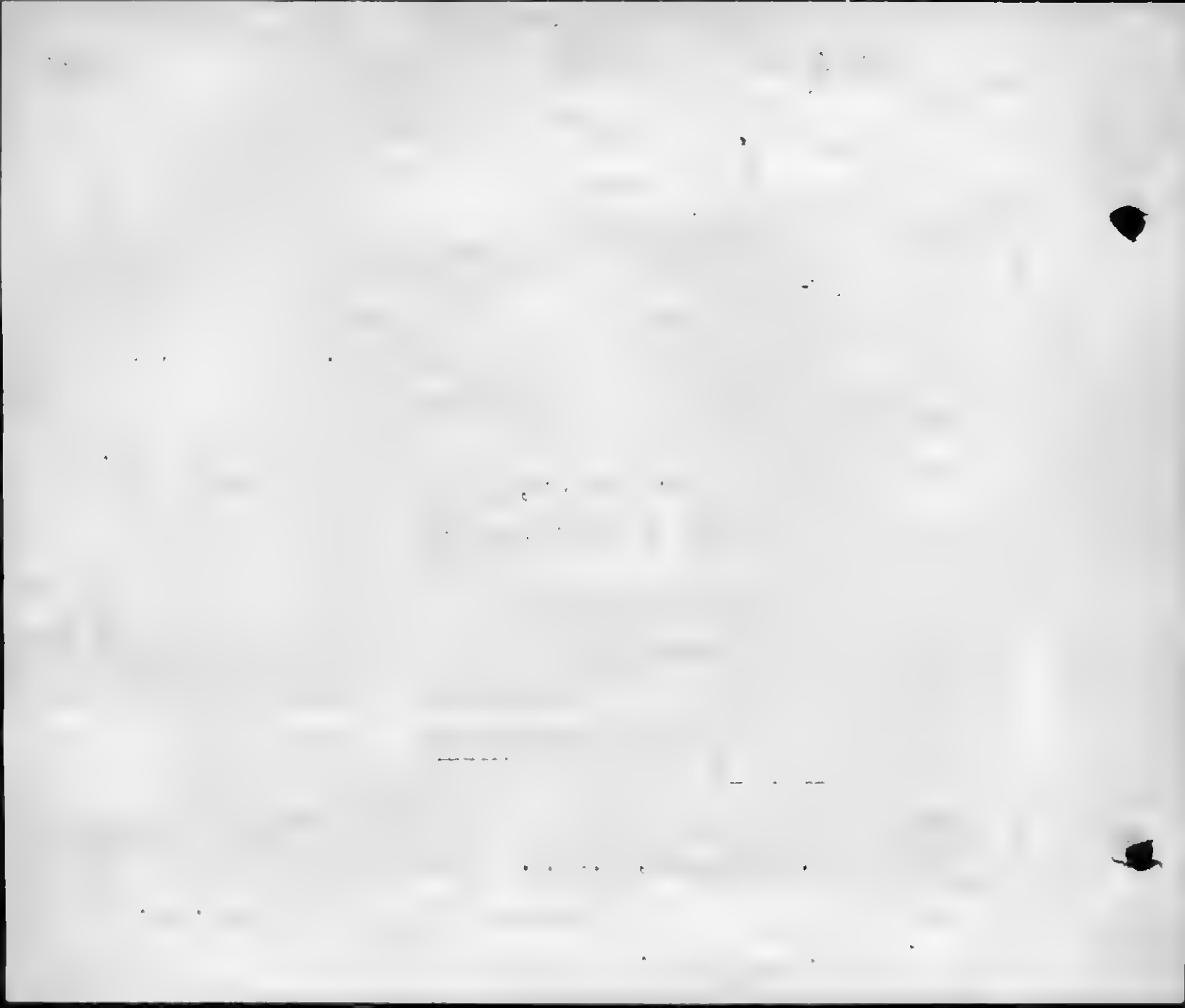
02804

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1012 Rosedale Heights Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u> d. STREET ADDRESS <u>1612 Rosedale Heights Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>STEPHEN</u> 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret-carpenter</u> 13. FATHER'S NAME <u>Stephen Riha</u>		8. DATE OF BIRTH <u>12/24/1894</u> 9. AGE (In years (if under 1 year) last birthday) Months Days Hours Min. <u>76</u> yrs. <u>March 2</u> 19 <u>61</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Czechoslovakia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>216-10-2368</u> 17. INFORMANT <u>William Riha, son, 13 Ferndale Ave.</u>		Address <u>Glen Burnie, Md.</u> 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u> (b) <u>Pulmonary metastases</u> (c) <u>Primary Carcinoma of Prostate</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>177X</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1960</u> to <u>March 2, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 2, 1961</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>John L. Cuth</u> 22c. PHYSICIAN'S NAME (Type) M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>3461</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3/6/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Bohemian Nat. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u> 25a. REC'D BY REGISTRAR DATE <u>MAR 7 '61</u> 25b. REGISTRAR'S SIGNATURE <u>J. H. H. H.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. Schilunek</u> ADDRESS <u>3331 Grebus Lane</u>			



0.11 - 0.4

VS. A15ME
5M 7/59



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

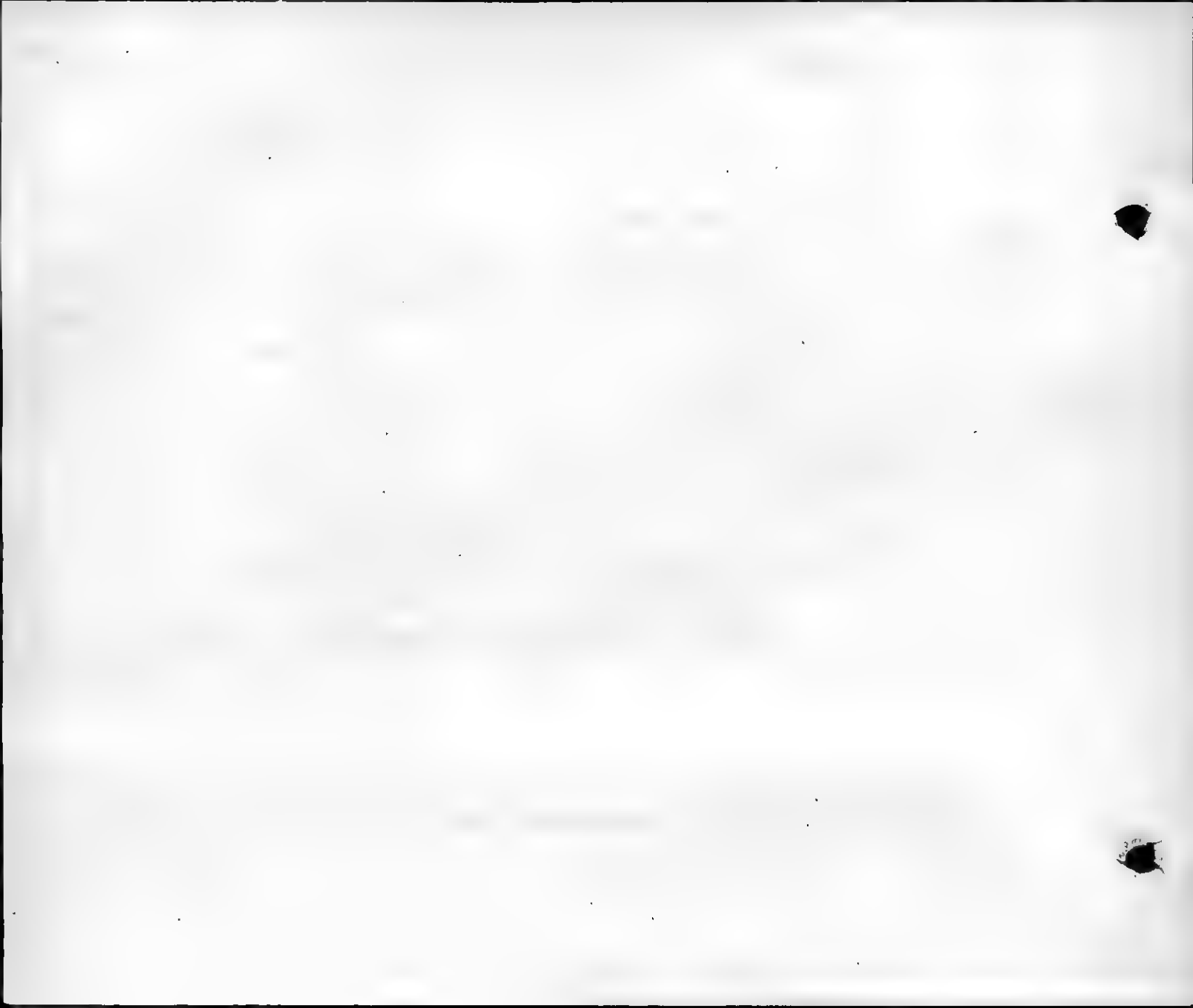
CERTIFICATE OF DEATH

Reg. Dist. No. 02806

2824

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Baltimore</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5227 Hamilton Ave.</u>				d. STREET ADDRESS <u>5227 Hamilton Ave</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Madeline</u> Last <u>Ritter</u>				4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 26, 1875</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Heilman</u>				14. MOTHER'S MAIDEN NAME <u>Mary</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Teresa M. Pressell</u>		Address <u>4211 Glenmore Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>1001</u> DUE TO <u>coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholecystitis, Hepatic Sclerosis, Hypertension</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part for Part II (a) item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1, 1961</u> to <u>March 10, 1961</u> , that I last saw the deceased alive on <u>March 10, 1961</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3001 S. Kensington Drive, Md.</u> DATE SIGNED <u>13</u>							
ACTUAL SIGNATURE <u>Walter A. Anderson</u>		PHYSICIAN'S NAME (Type) <u>Walter A. Anderson</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-14-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Cuche Son</u>				ADDRESS <u>900 N. Chester St.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 13 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. ☒ Reading physician. ☒ Filled in by the funeral director. After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
2825 Item 1c Film C282 3/9/61 mh 02807											
1. PLACE OF DEATH a. COUNTY Baltimore				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3 Mths. 3 Days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1808 Poplar Grove St.			
3. NAME OF DECEASED (Type or print) Hazel				4. DATE DEATH March 3, 1961				5. SEX Female			
6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH May 3, 1890			
9. AGE (In years last birthday) 70 yrs.				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (County & State, or foreign country) Maryland			
10b. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Records: Spring Grove State Hospital				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Azotemia DUE TO (b) Chronic glomerulonephritis DUE TO (c) Cerebral arteriosclerosis with psychotic reaction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis with psychotic reaction				INTERVAL BETWEEN ONSET AND DEATH 2 weeks years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from 11/30/60 to 3/3/61, 1961, that (I) (we) last saw the deceased alive on 3/3/61, and that death occurred at 8:40 P.M. from the causes and on the date stated above.											
22a. SIGNATURE IRYING M. DERBY				22b. DATE SIGNED 3/4/61				22c. PHYSICIAN'S NAME (Type) IRYING M. DERBY			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF MAR. 6, 1961				23c. NAME OF CEMETERY OR CREMATORY LODGEN PARK CEM.			
23d. LOCATION (City, town or county) Baltimore, Md.				23e. (State) Md.				23f. (Country)			
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Md.				24b. ADDRESS				25a. REC'D BY REGISTRAR DATE MAR 7 '61			
25b. REGISTRAR'S SIGNATURE John S. Harris				25c. (State)				25d. (Country)			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

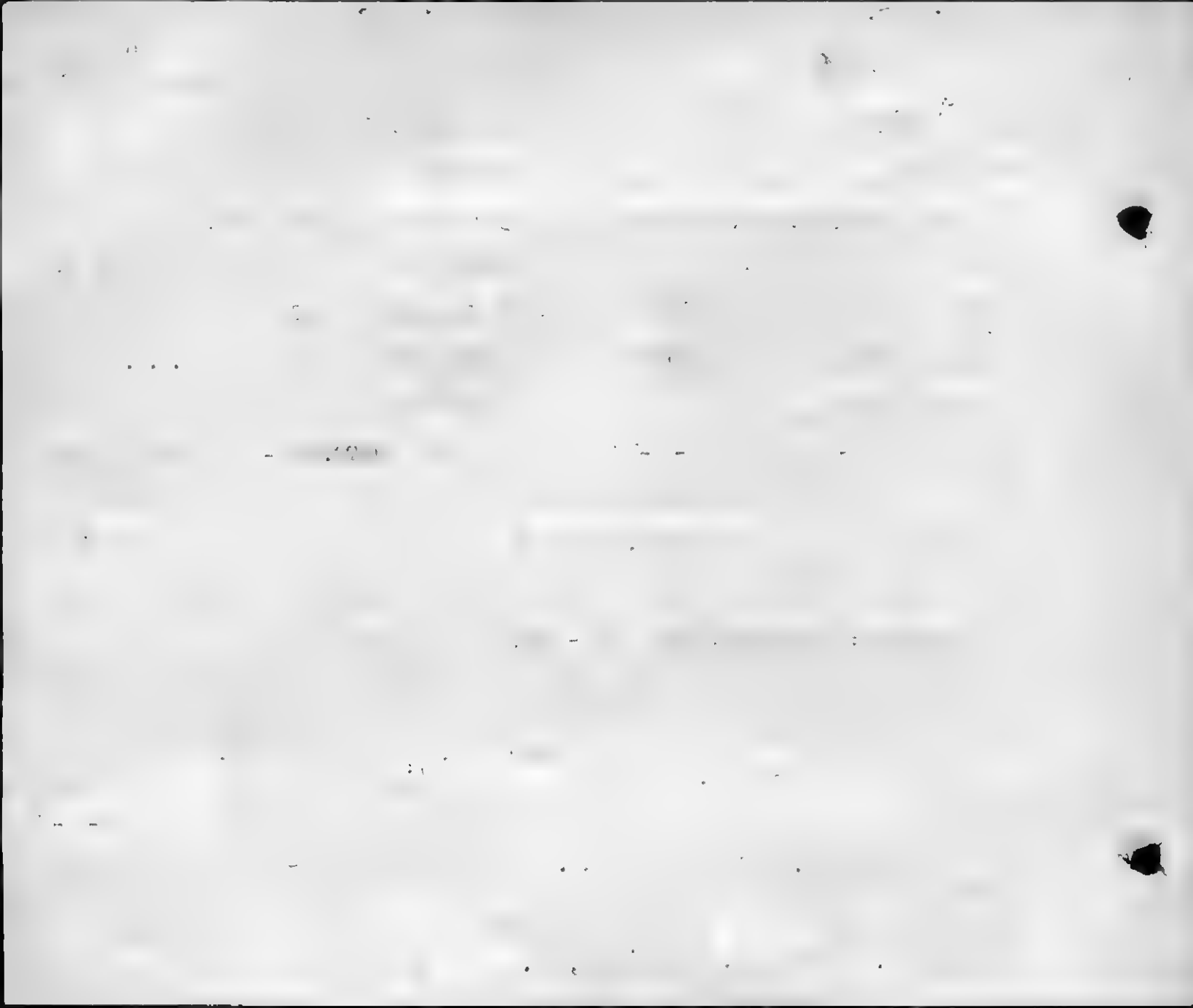
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2826

CERTIFICATE OF DEATH

02808

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN b. MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3600 EAST BALTIMORE STREET d. STREET ADDRESS 3600 EAST BALTIMORE STREET	
3. NAME OF DECEASED (Type or print) JAMES W ROBINSON First Middle Last 4. DATE OF DEATH MARCH 18 19 61 Month Day Year 9. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR: Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 30 1899 9. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERINTENDENT 10b. KIND OF BUSINESS OR INDUSTRY CEMETERY 11. BIRTHPLACE (County & State, or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME THOMAS ROBINSON 14. MOTHER'S MAIDEN NAME SADIE BAKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WW-1 16. SOCIAL SECURITY NO 216-09-1427 17. INFORMANT CLIN REC VAH BALTO. MD - FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO (b) CARCINOMA, LEFT LUNG DUE TO (c) 163 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 4 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): OPERATION: RESECTION, LEFT LUNG - 1957		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 15, 1961 to March 18, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 18, 1961 , and that death occurred at 7:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Paul G. Koukoulas M.D. 22c. PHYSICIAN'S NAME (Type) PAUL G. KOUKOULAS M.D. 22d. ADDRESS VAH BALTIMORE MD - FT HOWARD DIVISION		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 3-18-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 3/21/61 23c. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL 23d. LOCATION (City, town or county) (State) BALTIMORE MARYLAND		24. FUNERAL DIRECTOR'S SIGNATURE FREDERICK D. MILLER, INC. ADDRESS 3019 E. Monument St Baltimore 5, Md. 25a. REC'D BY REGISTRAR MAR 20 '61 25b. REGISTRAR'S SIGNATURE Arthur J. Hanes	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2827

CERTIFICATE OF DEATH

Item 8 Film 6283 3/30/61 mb

02809

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. LENGTH OF STAY IN 1b <u>63 years</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Baltimore, Maryland</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u>		d. STREET ADDRESS <u>120 S. Fulton Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Benedict Rosendale</u>		4. DATE OF DEATH Month <u>3</u> Day <u>23</u> Year <u>1961</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/31/88</u>		9. AGE (In years last birthday) <u>78</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>8</u> Hours <u>15</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>dependent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Christopher Rosendale (deceased)</u>		14. MOTHER'S MAIDEN NAME <u>Mary Rosemer (deceased)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>			
17. INFORMATION <u>Rosewood Records, Owings Mills, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive pulmonary embolism</u> DUE TO (b) <u>Thrombosis of femoral vein, right</u> DUE TO (c) <u>arteriosclerotic heart disease</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>8/28</u> Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <u>8/28</u> , 1897 to <u>3/23</u> , 1961, that (I) (we) last saw the deceased alive on <u>1961</u> , and that death occurred at <u>1961</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>W. Rieckert</u>		22b. DATE SIGNED <u>3-24-61</u>		22c. PHYSICIAN'S NAME (Type) <u>W. Rieckert</u>		22d. ADDRESS <u>4307 Mainfield Ave Balto 14</u>		22e. REC'D BY REGISTRAR <u>S. Rieckert</u>		22f. REGISTRAR'S SIGNATURE <u>Arthur S. Rieckert</u>		22g. DATE <u>MAR 27 1961</u>		22h. SIGNATURE <u>Arthur S. Rieckert</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/27/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		23d. LOCATION (City, town or county) (State) <u>Balto Md</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Luck</u>		24b. ADDRESS <u>5305 Bayford Rd</u>		24c. DATE <u>MAR 27 1961</u>		24d. SIGNATURE <u>Arthur S. Rieckert</u>		24e. DATE <u>MAR 27 1961</u>	





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2829

CERTIFICATE OF DEATH

02811

1. PLACE OF DEATH

a. COUNTY

BALTIMORE

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

FORT HOWARD

c. LENGTH OF STAY N 1b

81 DAYS

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

VETERANS ADMINISTRATION HOSPITAL

3. NAME OF DECEASED (Type or print)

First

CLARENCE

Middle

--

2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission; If institution)

a. STATE

MARYLAND

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

BALTIMORE

d. STREET ADDRESS

1902 CEDRIC ROAD

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

4. DATE OF DEATH

Month

MARCH

Day

18, 19 61

Year

5. SEX

MALE

6. COLOR OR RACE

COLORED

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

APRIL 11 1894

9. AGE (In years last birthday)

66 yrs.

10. IF UNDER 1 YEAR, IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10b. KIND OF BUSINESS OR INDUSTRY

ODD JOBS

11. BIRTHPLACE (County & State, or foreign country)

WARWICK CO., VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

WINNIE ROWSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

YES

WW-1

16. SOCIAL SECURITY NO.

219-01-5006

17. INFORMANT

Address

CLIN REC VAH BALTIMORE MD FT HOWARD DIVISION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

CARCINOMA, RIGHT LUNG

INTERVAL BETWEEN ONSET AND DEATH UNKNOWN

16 \geq X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that ☒ (this hospital) attended the deceased from December 27, 1960, to March 18, 1961, that ☒ (we) last saw the deceased alive on March 18, 1961, and that death occurred at 7:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

THOMAS F. CRAHAN, M.D.

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22d. ADDRESS

VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION

22b. DATE SIGNED 3/20/61

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

3-22-61

23c. NAME OF CEMETERY OR CREMATORY

Baltimore National

23d. LOCATION (City, town or county)

Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Arlington S. Phillips

ADDRESS

1808 N. Monroe Street
Baltimore 17, Maryland

25a. REC'D BY REGISTRAR

DATE MAR 23 '61

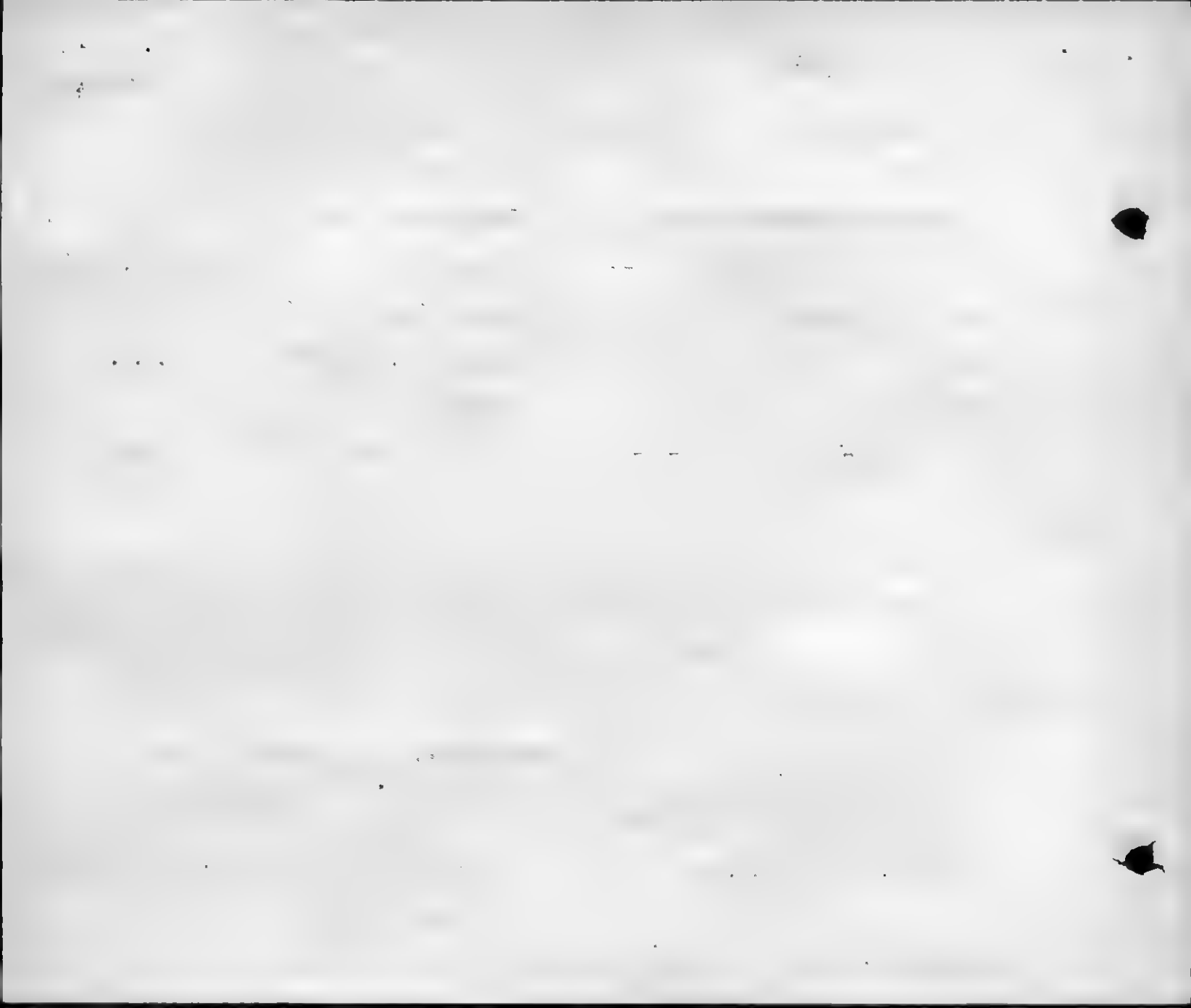
25b. REGISTRAR'S SIGNATURE

Arlington S. Phillips

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60



1
FOR STATE
HEALTH DEPT.

M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2830 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02812

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE [Where deceased lived, if institution; Residence before admission] e. STATE <u>Md.</u> b. COUNTY _____			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
c. LENGTH OF STAY IN 1b _____				d. STREET ADDRESS <u>1606 Thetford Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7501 York Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Gary</u>		First Middle Last		4. DATE OF DEATH <u>3 - 18 - 1961</u>		Month Day Year	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-18-1958</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10a. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Leon J. Rozankowski</u>				14. MOTHER'S MAIDEN NAME <u>Lorraine Kelbaugh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) _____				16. SOCIAL SECURITY NO _____			
17. INFORMANT <u>Leon J. Rozankowski</u>				Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Purulent Meningitis</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
SIGNATURE <u>William J. Spindel</u>				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> 3/19/61 DATE SIGNED			
EXAMINER'S NAME (Type) _____				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3-22-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Mem.</u>		22d. LOCATION (City, town, or county) <u>Baltimore County, Md.</u> (State) _____	
23. FUNERAL DIRECTOR <u>Leonard J. Ruck 5305 Hargord Rd.</u>				24a. REC'D BY REGISTRAR <u>MAR 21 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2831

CERTIFICATE OF DEATH

Reg. Dist. No. 02813

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>		c. LENGTH OF STAY IN 1b <u>34RS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>736 Peach Cr. Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lola BEVEN Mac Russell</u>		4. DATE OF DEATH <u>March 22 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 6, 1883</u>
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR <u>—</u> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Andrew MEERS</u>		14. MOTHER'S MAIDEN NAME <u>MARY Sneed</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-01-7584</u>	
17. INFORMANT <u>Nellie Murphy</u>		Address <u>2012 St. Hood Ave. Balto 17, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial</u> <u>Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>Arterio-sclerosis @ Bronchial Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>14 days</u> <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 1959</u> to <u>March 22, 1961</u> that I last saw the deceased alive on <u>MARCH 22, 1961</u> and that death occurred at <u>9:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Stodo</u> M.D.		DATE SIGNED <u>3-22-61</u>	
PHYSICIAN'S NAME (Type) <u>William C. Wadsworth</u>		<u>Dundalk 22, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-25-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARBUTUS PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM A. JACKSON F.H. INC.</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>—</u> DATE <u>MAR 28 1961</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

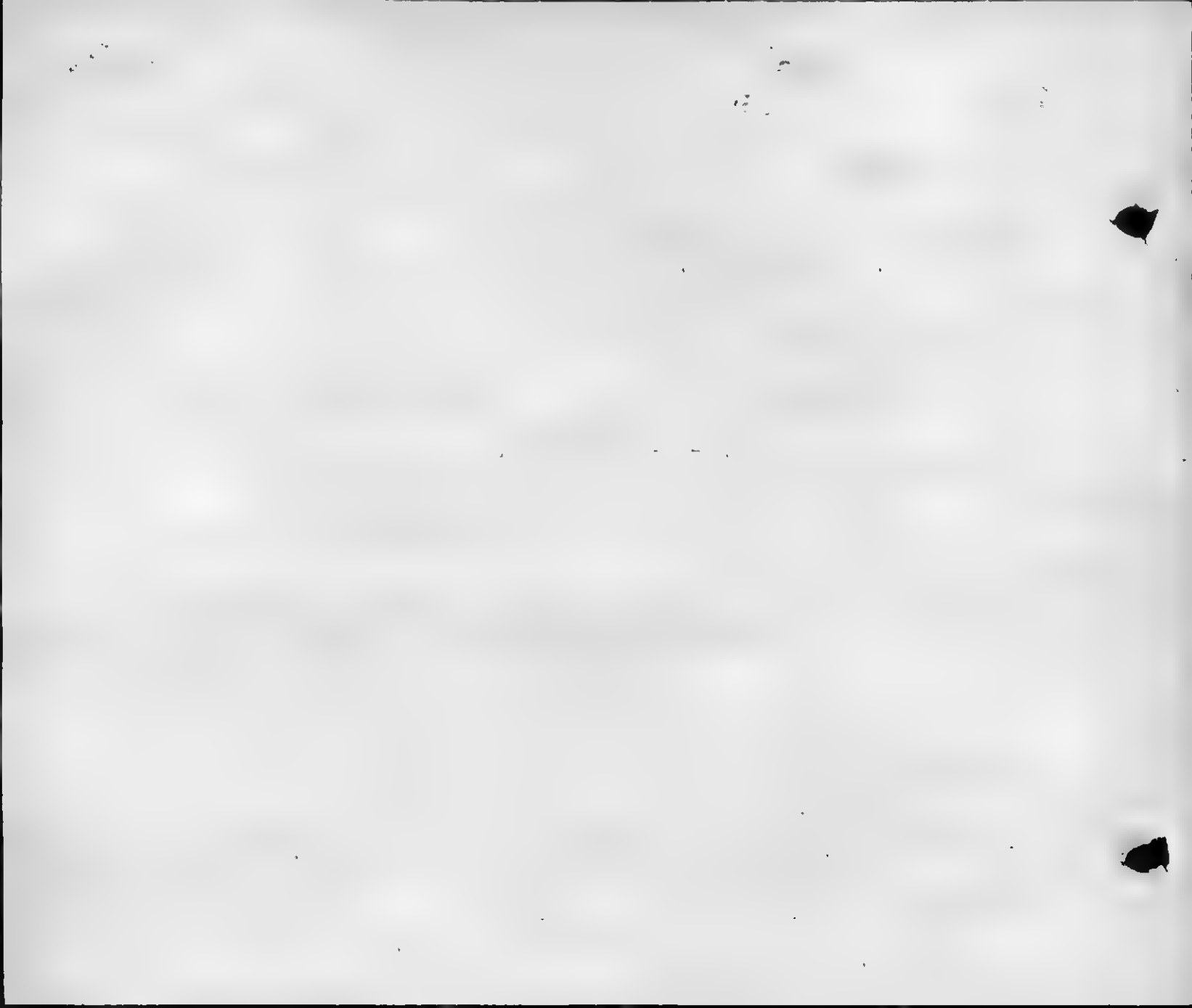
CERTIFICATE OF DEATH

2832

02814

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 6</u> c. LENGTH OF STAY IN <u>6</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 6</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5435 Radecke Avenue</u>		d. STREET ADDRESS <u>5435 Radecke Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. George F. Sadowsky</u>		4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>19 61</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan 19, 1889</u>	9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Retail Grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Sadowsky</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Ziegler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <u>212-03-3626A</u>		17. INFORMANT <u>Miss Grayce Sadowsky</u> Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>421.0</u> DUE TO <u>Acute Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Arterio Sclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(1) Peripheral Vascular Disease (2) Post-operative Status Amputation Left Leg</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Left Leg</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>5356 Reisterstown Rd</u>		20f. City or town (County) (State)	
21. I certify that (I) (th's hospital) attended the deceased from <u>8/4/50</u> to <u>3/3/61</u> , that (I) (we) last saw the deceased alive on <u>Dec 10, 1960</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Julius C. Gluck</u> M.D.		22b. DATE SIGNED <u>3/4/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Julius C. Gluck, M.D.</u>		22d. ADDRESS <u>5356 Reisterstown Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-6-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 7 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>John S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



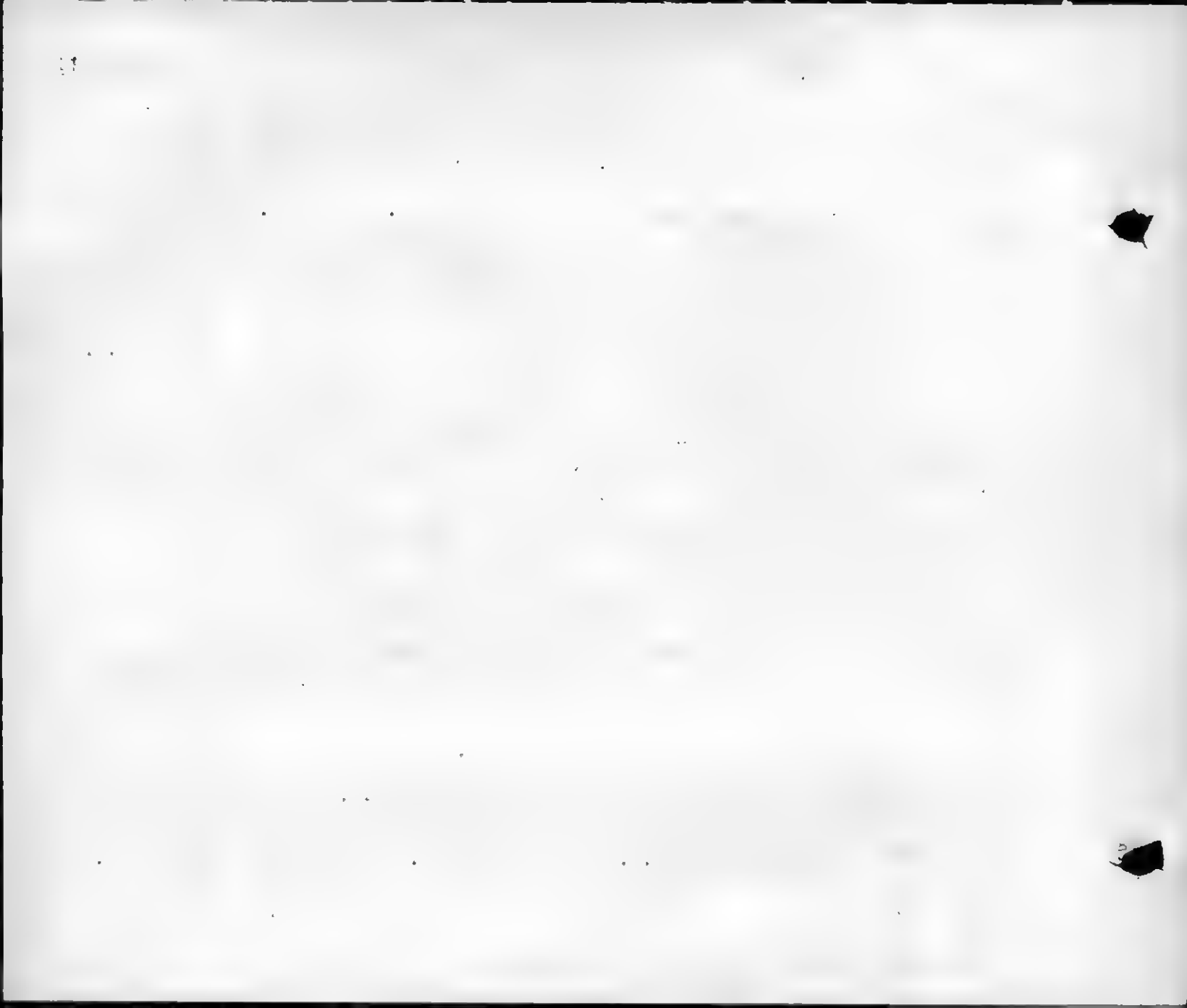
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
02815

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Res'dence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		d. STREET ADDRESS 1030 E. North Ave.	
3. NAME OF DECEASED (Type or print) First Mamie Middle Sauer Last Sauer		4. DATE OF DEATH Month March Day 20 Year '61	
5 SEX F	6 COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12/11/1878
9 AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 20 Days 20 Hours 20 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Gallagher		14. MOTHER'S MAIDEN NAME Emma Mc Comas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-03-5024	
17 INFORMANT Admission Records		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral DUE TO Lat. Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Sept. 1960 to March 1961 , that (I) (we) last saw the deceased alive on 3/19/1961 , and that death occurred at 2:20 A.M. from the causes and on the date stated above 22a. SIGNATURE Robert J. Mahon M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c PHYSICIAN'S NAME (Type) Robert Mahon, M.D. 22d. ADDRESS 602 E. Joppa Road - Towson, Md. 22b. DATE SIGNED 23a BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF March 22-61 23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery 23d. LOCATION (City, town, or county) (State) Old Frederick Rd. Baltimore 24. FUNERAL DIRECTOR'S SIGNATURE Joseph B. 7110 Belair Rd. ADDRESS 25a. REC'D BY REGISTRAR DATE MAR 22 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

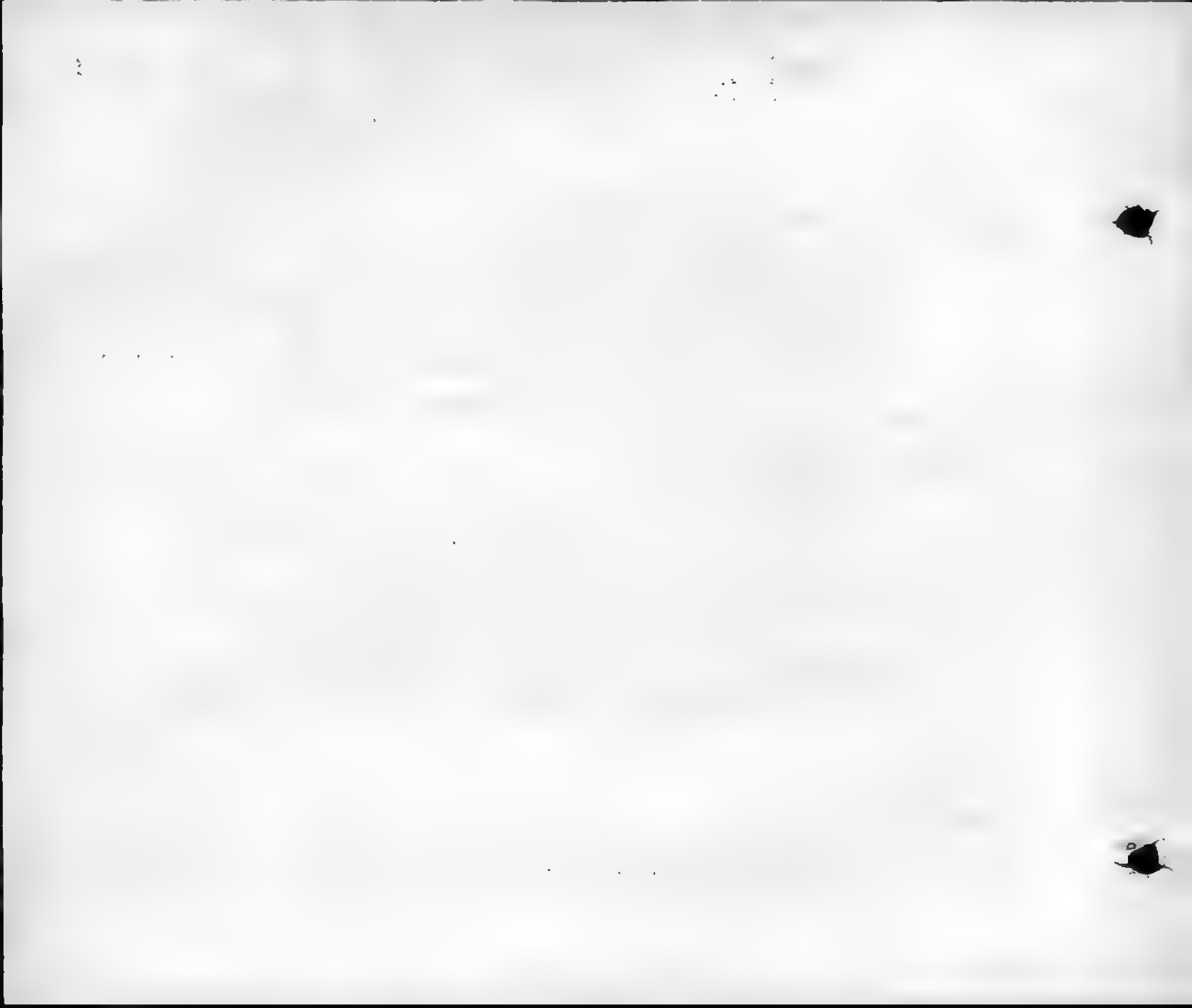
Reg. Dist. No. **02816**

2834

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 25yr10mth8dys d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4100 E. Lombard Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Schenning First Middle Last		4. DATE OF DEATH Month March Day 17 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1879 9. AGE (In years last birthday) 81 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) proprietor		10b. KIND OF BUSINESS OR INDUSTRY restaurant	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Henry Schenning		14. MOTHER'S MAIDEN NAME MARY ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X cerebral vascular accident DUE TO (b) cerebral arteriosclerosis DUE TO (c) generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes, malnutrition			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan. 22, 1961 , to March 17, 1961 , that I last saw the deceased alive on March 17, 1961 , and that death occurred at 6:42 AM , from the causes and on the date stated above			
ACTUAL SIGNATURE Stella Wachler		M.D. SPRING GROVE STATE HOSPITAL DATE SIGNED 3-17-61	
PHYSICIAN'S NAME (Type) Stella Wachler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-20-61	22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM	22d. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD., MD.
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Geiler ADDRESS 9015 CONKLING ST. BALTO., 24, MD.		24a. REC'D BY REGISTRAR MAR 20 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL: OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2835

CERTIFICATE OF DEATH

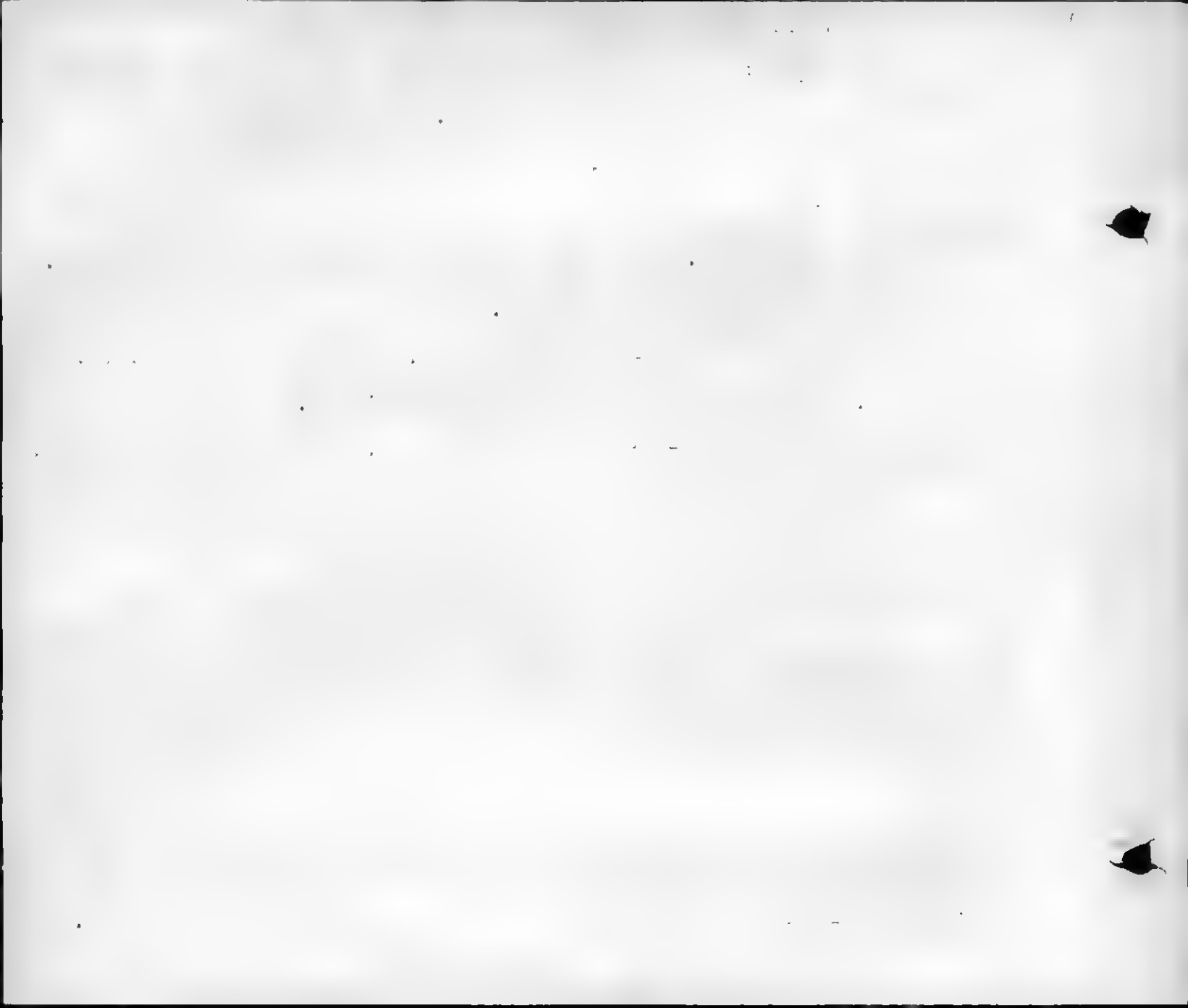
Reg. Dist. No. 02817

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. LENGTH OF STAY IN IB <u>9 Yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2011 Oak Drive</u>		e. STREET ADDRESS <u>2011 Oak Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cecelia B. Schnitt</u>		4. DATE OF DEATH Month Day Year <u>March 25, 1961.</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 23, 1892</u>
9. AGE (In years last birthday) <u>68</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hairdresser</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George N. A. Schnitt</u>		14. MOTHER'S MAIDEN NAME <u>Katherine M. Ludwig</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>214-14-4649</u>	
17. INFORMANT Address <u>Miss Dorothy H. Ludwig 115 Rosewood Ave. (28)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/9/56</u> , 19____, to <u>2/26/61</u> , 19____, that I last saw the deceased alive on <u>2/20/61</u> , 19____, and that death occurred at <u>6 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Milton Schlusoff</u>		ADDRESS (Street, city or town, state) <u>6410 W. Union Mill Rd Baltimore Md.</u>	
PHYSICIAN'S NAME (Type) <u>Milton Schlusoff</u>		DATE SIGNED <u>3/26/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-28-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard Strong</u>		ADDRESS <u>3207 W. North Ave</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 28 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>	

MEDICAL CERTIFICATION

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2836

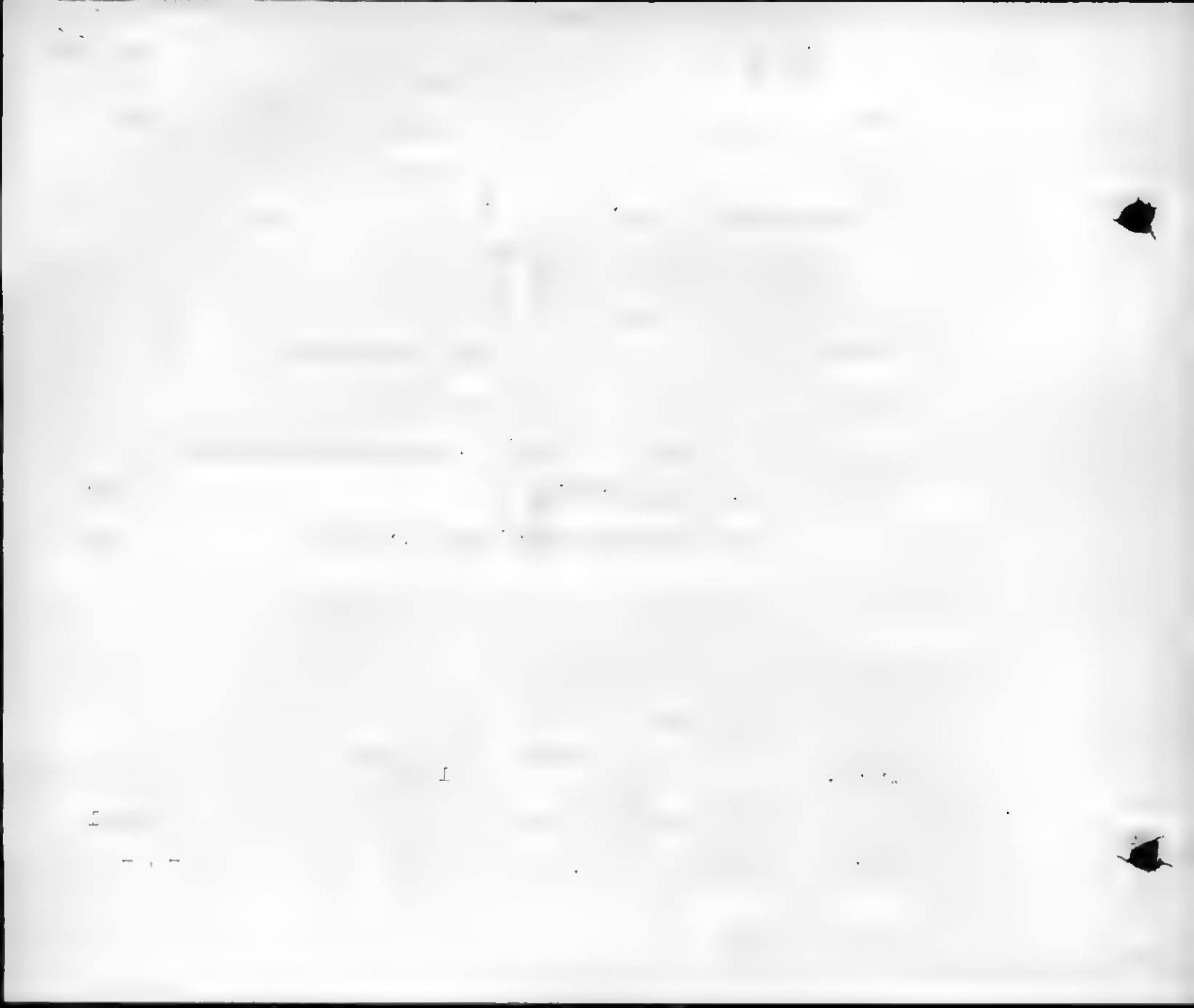
CERTIFICATE OF DEATH

Reg. Dist. No. 02818

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. LENGTH OF STAY IN 1b Woodlawn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5309 XXXX Lewellen Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARY ANGELA SCHMITT				4. DATE OF DEATH Month Day Year March 6 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1896	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Nesor				14. MOTHER'S MAIDEN NAME Mary Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Louis R. Schmitt=5309 Lewellen Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 1 hour 5 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) *****				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) *****			
20c. TIME OF INJURY Month, Day, Year Hour: ***** p. m. 19 61		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work *****		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) *****		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1959 to March 1961 that I last saw the deceased alive on March 6, 1961 and that death occurred at 1:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 3/7/61							
ACTUAL SIGNATURE Millard T. Traband, Jr. M.D.							
PHYSICIAN'S NAME (Type) Millard T. Traband, Jr., M.D.				5101 Gwynn Oak Avenue - 7 -			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/9/1961		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost				24a. REC'D BY REGISTRAR MAR 9 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
Ellsworth Armacost-4600 Liberty Hgts. Ave.							

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

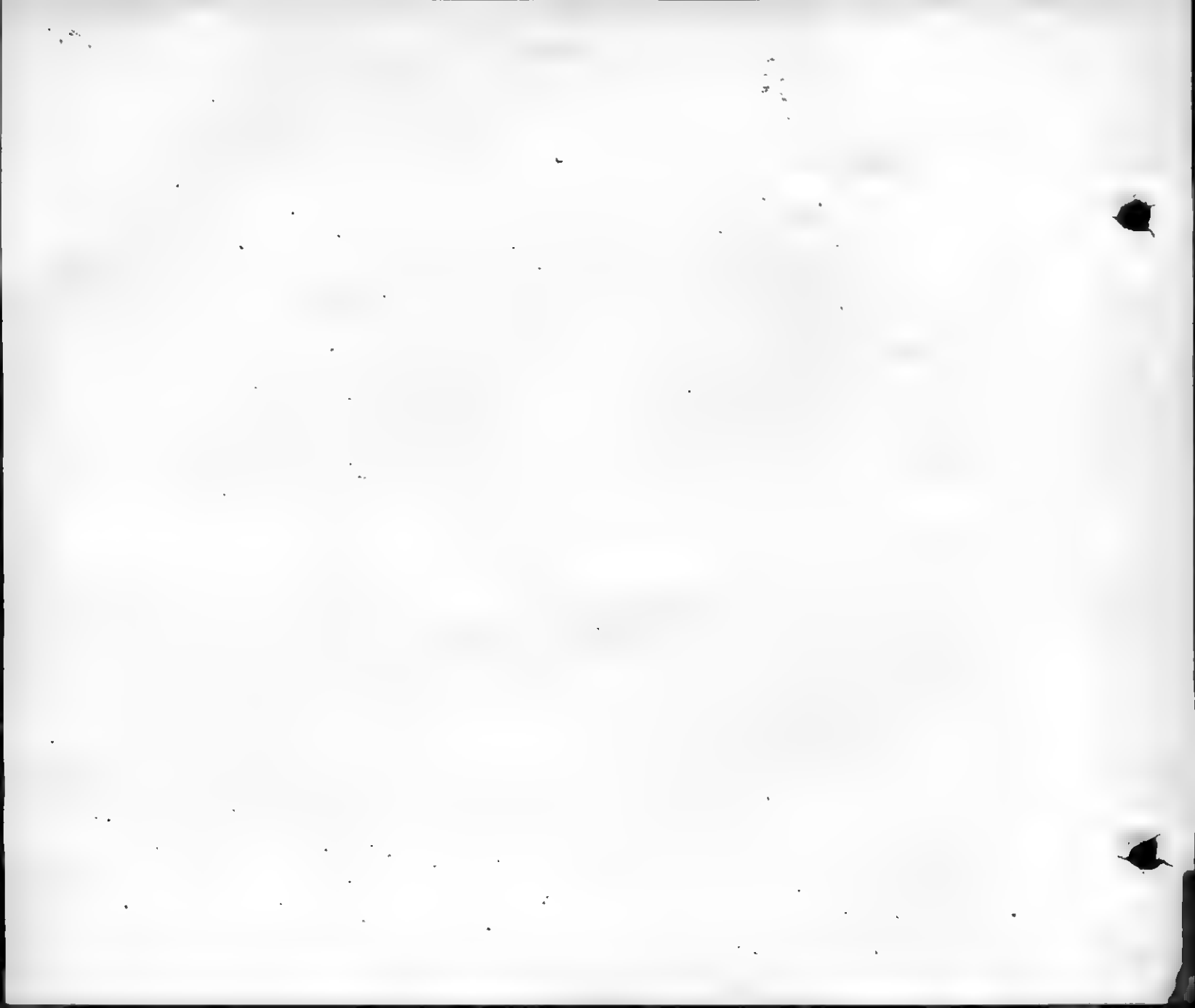


2837

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md</u>		b. COUNTY <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>16815 Campbell Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>SOPHIA</u> Middle <u>SCHNEIDER</u> Last <u>SCHNEIDER</u>		4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan <u>28</u> , 1872		9. AGE (In years lost birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Household</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Leo Schneider</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Eck</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>544-14-1000</u>									
17. INFORMANT <u>Earl L. Chambers</u>		Address <u>544-14-1000</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart Disease</u> 420.0) DUE TO (b) <u>Generalized Arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u>Generalized Arterio-sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 13</u> , 19 <u>61</u> , to <u>March 13</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 13</u> , 19 <u>61</u> , and that death occurred at <u>4:35 P.M.</u> , from the causes and on the date stated above.		22a. ACTUAL SIGNATURE <u>Earl L. Chambers</u>		22b. PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>		22c. ADDRESS (Street, city or town, state) <u>4108 Liberty Hts Baltimore Md</u>		22d. DATE SIGNED <u>3/13/61</u>		22e. NAME OF CEMETERY OR CREMATORY <u>Greenhill St</u>		22f. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>		22g. DATE THEREOF <u>3/16/61</u>		22h. NAME OF REGISTRAR <u>Harold Newman</u>		22i. ADDRESS <u>Hay Rd</u>		22j. DATE <u>MAR 16 1961</u>		22k. REGISTRAR'S SIGNATURE <u>Harold Newman</u>	



CERTIFICATE OF DEATH

Reg. Dist. No. 02820

2838

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>125 Forrest Ave.</u>				d. STREET ADDRESS <u>125 Forrest Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>William J. Schreiber</u>				4. DATE OF DEATH <u>March 13 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 19-1873</u>	9. AGE (in years last birthday) <u>88</u> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Const.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>William Schreiber</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u>		16. SOCIAL SECURITY NO. <u>[blank]</u>		17. INFORMANT <u>Mrs. Richard Messop-125 Forrest Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>3 mo</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic disease of prostate</u> DUE TO <u>2 yrs</u> (c) <u>Senility</u> 5 yrs				INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>[blank]</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 58</u> , 19 <u>58</u> , to <u>March 1961</u> , that I last saw the deceased alive on <u>March 12, 1961</u> , and that death occurred at <u>7:25</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. B. Brumbaugh, M.D.</u>				ADDRESS (Street, city or town, state) <u>5609 Main St</u>			
PHYSICIAN'S NAME (Type) <u>B. B. Brumbaugh</u>				DATE SIGNED <u>March 27 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/16/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Neppert-1300 Eutaw Pl.</u>				24a. REC'D BY REGISTRAR <u>[blank]</u>		24b. REGISTRAR'S SIGNATURE <u>[blank]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2845

CERTIFICATE OF DEATH

02821

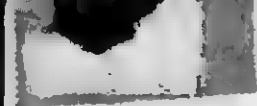
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>29yr7mth7days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>4205 Woodstock Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul</u> <u>Smith</u> <u>Senner</u> First Middle Last		4. DATE OF DEATH <u>March</u> <u>10</u> <u>19</u> <u>61</u> Month Day Year		9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sheet metal worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John D. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Susal Killian</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic lesion of lungs</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. (c) <u> </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>March 5, 1961</u> <u>8:09</u> <u>AM</u> to <u>March 10, 1961</u> that (I) (we) last saw the deceased alive on <u>March 10, 1961</u> and that death occurred at <u> </u> <u> </u> <u> </u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Stella Wachsler, M.D.</u>		22b. DATE SIGNED <u>3-10-61</u>		22c. PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		23b. DATE THEREOF <u>3-29-61</u>		23c. NAMES OF CEMETERY OR CREMATORY <u> </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u> </u>		24b. ADDRESS <u> </u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. DATE <u>APR 3 '61</u>		25d. REGISTRAR'S SIGNATURE <u> </u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
2839 CERTIFICATE OF DEATH 2829															
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>76 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Annes</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u> d. STREET ADDRESS <u>310 S. Commerce Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>JOHN M. SHAW</u>				4. DATE OF DEATH <u>March 16 1961</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 4, 1893</u> 9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile Agency</u>				11. BIRTHPLACE <u>Cordova, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Joseph Shaw</u>				14. MOTHER'S MAIDEN NAME <u>Eliza J. Towers</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>217-05-3717</u>				17. INFORMANT Address <u>Clinical Records, VAH, BALTIMORE 18, Maryland</u> <u>FORT HOWARD DIVISION</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (b) <u>PULMONARY EMPHYSEMA, MARKED</u> (c) <u>POST-OPERATIVE STATE-NEPHRECTOMY FOR CARCINOMA, KIDNEY</u> cause last. <u>RECENT</u>				INTERVAL BETWEEN ONSET AND DEATH <u>RECENT</u> <u>UNKNOWN</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1. <u>Cerebral Thrombosis (Clinical). Carcinoma Thyroid with Metastases to Superior Mediastinum.</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (he/she) attended the deceased from <u>December 30, 1960</u> , to <u>March 16, 1961</u> , that (he/she) last saw the deceased alive on <u>March 16, 1961</u> , and that death occurred at <u>8:50 AM</u> , from the causes and on the date stated above.															
22a. SIGNATURE <u>Thomas F. Crahan</u>				22b. DATE <u>3/16/61</u>				22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. CRAHAN, M.D.</u>				22d. ADDRESS <u>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>MARCH 18 1961</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Centreville, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Barton Brothers Funeral Home</u>				25a. REC'D BY REGISTRAR <u>DATE MAR 21 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				25c. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

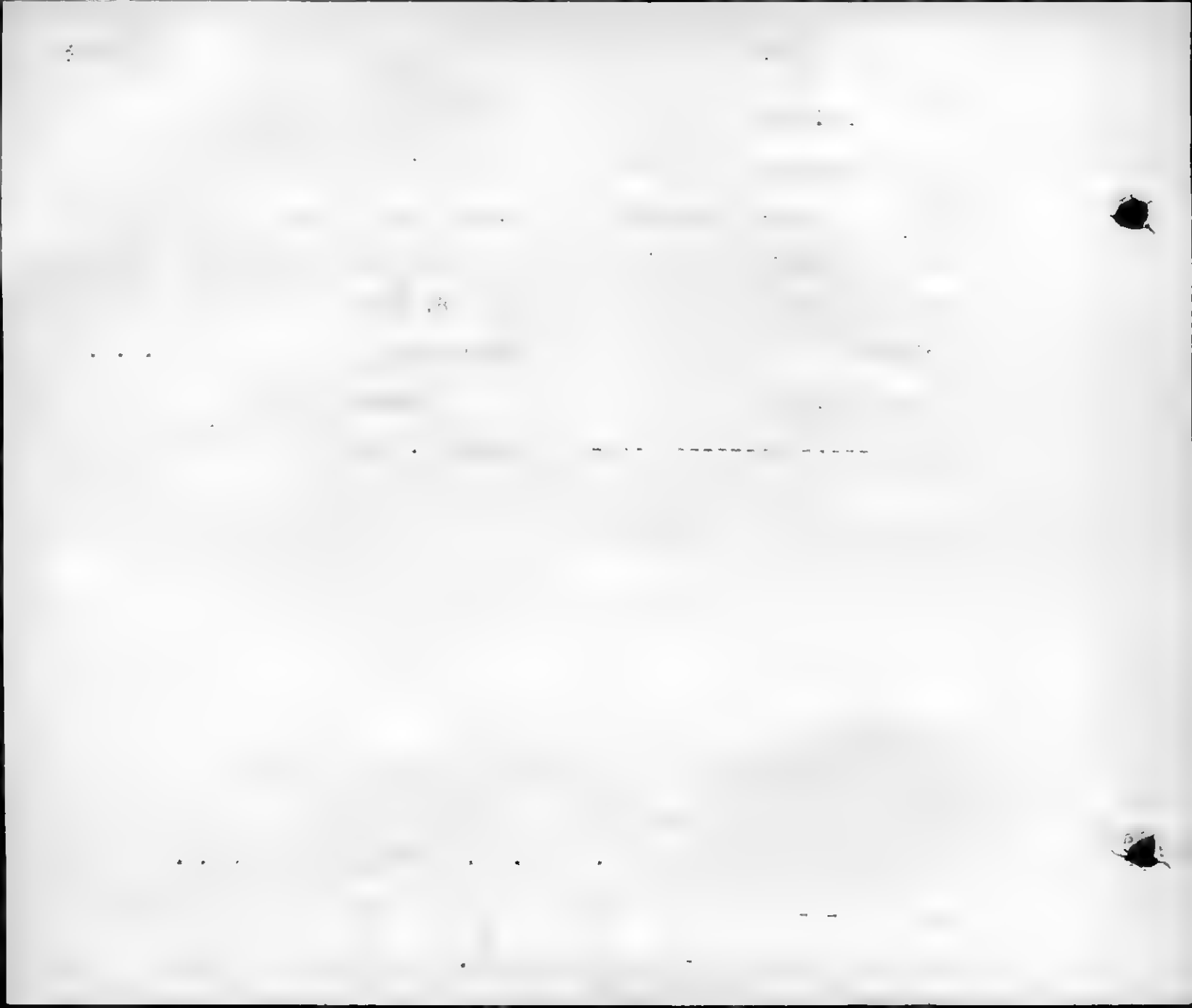
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2840

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02824

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Halethorpe				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Sipple Last				4. DATE OF DEATH Month March Day 5 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 28, 1874	
9. AGE (In years last birthday) 86 yrs		10. UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME George Sipple				14. MOTHER'S MAIDEN NAME Laura Easley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs Alice G. Sipple				Address 1256 Francis Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Generalized Arteriosclerosis DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 wk 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1, 1961 to March 5, 1961 , that (I) (we) last saw the deceased alive on March 4, 1961 , and that death occurred at 4:30 M., from the causes and on the date stated above							
22a. SIGNATURE A. Bradley Daugharthy				22b. ADDRESS 1264 Francis Avenue Balto. 27, Md.			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS A. Bradley Daugharthy, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-7-1961		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City, town, or county) (State) North Ave Balto Md	
24. FUNERAL DIRECTOR'S SIGNATURE Leo G. Cook & Son 1701-03 Patterson Pk.				25a. REC'D BY REGISTRAR Mar 8 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kneave	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2841

CERTIFICATE OF DEATH

Reg. Dist. No.

02711

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road		d. STREET ADDRESS Glenarm Road	
3. NAME OF DECEASED (Type or print) First Sister Mary Expedita Frey Middle Frey Last Frey		4. DATE OF DEATH Month March Day 6 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 13, 1873
9. AGE (In years last birthday) 88 yrs		IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min 88	IF UNDER 24 HRS Months 88 Days 88 Hours 88 Min 88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS	
11. BIRTHPLACE (State or foreign country) Milford Township, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Frey		14. MOTHER'S MAIDEN NAME Josephine Steingruber	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sister M. Peter Fourrier		Address Notch Cliff, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arterio- sclerosis DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 2 mos. 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 1952 , to March 1961 , that I last saw the deceased alive on March 2, 1961 , and that death occurred at 10:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7501 York Road Towson 4, Md. DATE SIGNED 3/6/61			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-8-61	22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.	22d. LOCATION (City, town, or county) (State) NOTCH CLIFF NR TOWSON, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Gailor		24a. REC'D BY REGISTRAR DATE MAR 8 '61	24b. REGISTRAR'S SIGNATURE Carl A. Gailor

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 02825

2842

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4508 Springwood Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Stepania</u> Middle <u>Slawakiewicz</u> Last <u>Slawakiewicz</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 15 1886</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Slawinski</u>		14. MOTHER'S MAIDEN NAME <u>Rodulfa</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Walter Slawakiewicz</u>		Address <u>4508 Springwood Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis, acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>10 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mitral stenosis and insufficiency. Paralytic ileus</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-16</u> , 19 <u>61</u> , to <u>3-12</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2-16</u> , 19 <u>61</u> , and that death occurred at <u>8:34 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Santi Amoroso</u>		ADDRESS (Street, city or town, state) <u>6801 Belair Rd, Balto. 6, MD</u>	
PHYSICIAN'S NAME (Type) <u>SANTI AMOROSO</u>		DATE SIGNED <u>3-13-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-15-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cem</u>		22d. LOCATION (City, town, or county) (State) <u>German Hill Rd, Balto, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deppel Bros 710 Belair Rd.</u>		ADDRESS <u>710 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>MAR 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2843

CERTIFICATE OF DEATH

Reg. Dist. No. 02827

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Turners Station</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Turners Station</u>			
c. LENGTH OF STAY IN 1b <u>16 yrs</u>				d. STREET ADDRESS <u>116 Walnut Avenue</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth Danival Smith</u>				4. DATE OF DEATH <u>March 24 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>10/13/45</u>		9. AGE (In years last birthday) <u>15</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Brakes Branch, Virginia</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13. FATHER'S NAME <u>Nathaniel Danival</u>				14. MOTHER'S MAIDEN NAME <u>Loretta Danival</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>55105</u>		17. INFORMANT <u>consistently reliable</u>		Address <u>116 Walnut Avenue</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> 55105 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>obesity</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While _____ Not while _____ at work _____ at work _____		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>March 24-61</u> to _____, 19____, that I last saw the deceased alive on <u>March 24-61</u> , and that death occurred at <u>5A</u> M, from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Dr. Thomas</u> M.D.				ADDRESS (Street, city or town, state) <u>107 N. Main St.</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Thomas M.D.</u>				DATE SIGNED <u>March 22 3/30/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/24/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Johnson</u> ADDRESS <u>1011-15 N. Arlington Ave.</u>				24a. REC'D BY REGISTRAR <u>APR 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Christina S. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2844

CERTIFICATE OF DEATH

02826

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Big Falls Rd.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>Big Falls Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Geo. I. Smith</u> First Middle Last 4. DATE OF DEATH <u>3/3/61</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>NEGO</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan. 14, 1891</u> 9. AGE (In years last birthday) <u>70</u> yrs IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>labour</u> 11. BIRTHPLACE (State or foreign country) <u>md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Geo. Smith</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-10-9581</u> 17. INFORMANT <u>Edith Johnson - Big Falls Rd. Baltimore, Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) <u>Arterio Sclerotic Cardio Vascular Disease</u> DUE TO (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1961</u> to <u>March 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 2, 1961</u> , and that death occurred at <u>3:15/4:00 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>C. Herbert Mueller Jr</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER JR</u>		22d. ADDRESS <u>PARKTON - MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/6/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Balto. Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. L. Chaturand - 1701 Mt. Cuthbert St. Balto. Md.</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

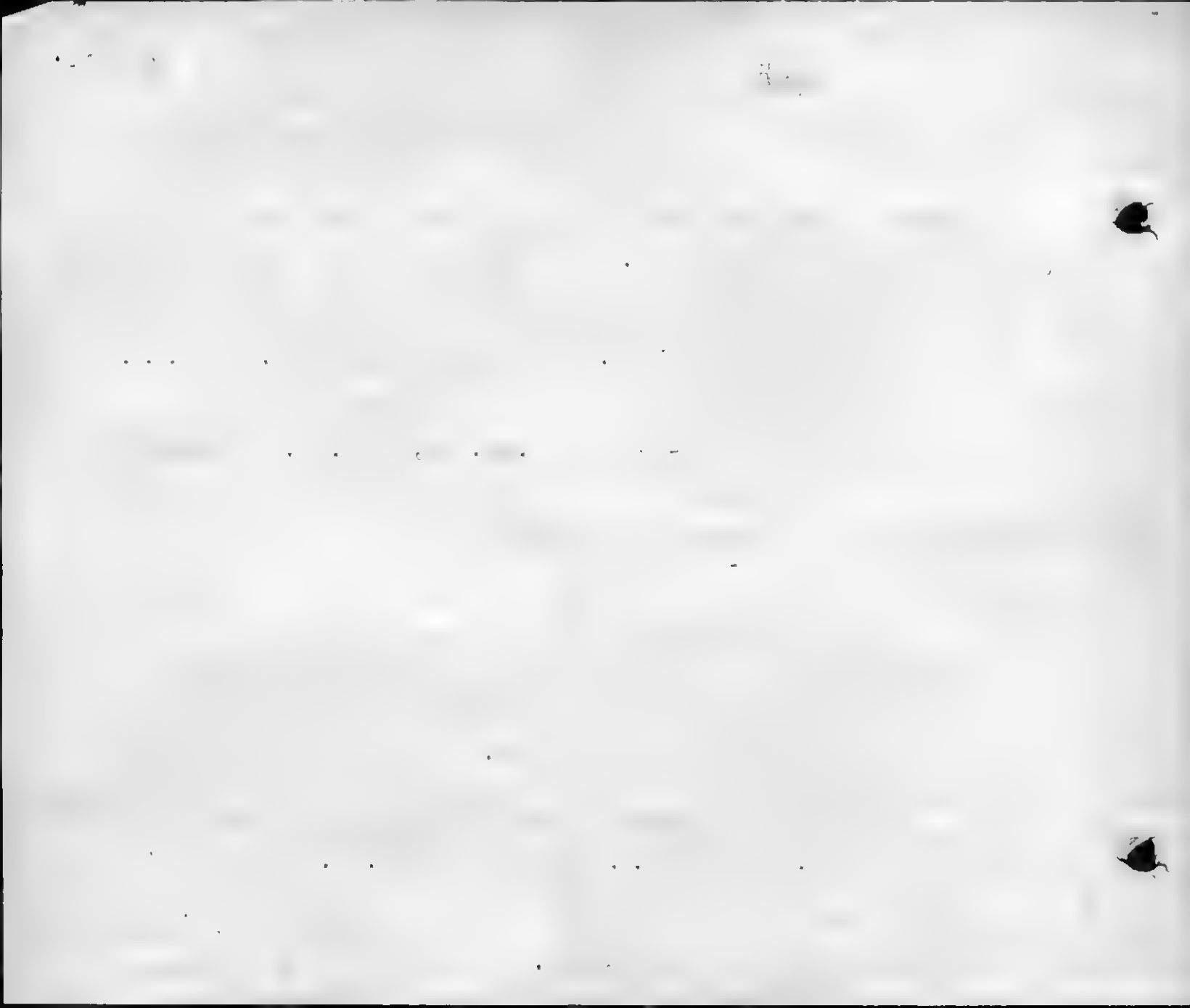


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
CERTIFICATE OF DEATH			
02828			
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN TB 74 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital			
3. NAME OF DECEASED (Type or print) RICHARD R. SMITH		4. DATE OF DEATH MARCH 18 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/14/21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		11. BIRTHPLACE (County & State, or foreign country) Natrona Heights, Penn.	
10b. KIND OF BUSINESS OR INDUSTRY Martin Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edmund Smith		14. MOTHER'S MAIDEN NAME Ava Faulkner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 171-14-8271	
17. INFORMANT Clin. Rec. VAH, Balto. Md. Fort Howard Division		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO 163 X		INTERVAL BETWEEN ONSET AND DEATH 48 HOURS	
Conditions, if any, which gave rise to immediate cause (b) CARCINOMA RIGHT LUNG WITH WIDE SPREAD METASTASES		UNKNOWN	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from Jan. 3 1961 to March 18 1961 , that (we) last saw the deceased alive on March 18 1961 , and that death occurred at 5:50 PM , from the causes and on the date stated above.			
22a. SIGNATURE Paul G. Koukoulas		22b. DATE SIGNED 3/18/61	
22c. PHYSICIAN'S NAME (Type) PAUL G. KOUKOULAS, M.D.		22d. ADDRESS VAH, Balto. Md. Fort Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 22, 1961	
23c. NAME OF CEMETERY OR CREMATORY Mt Airy Cemetery		23d. LOCATION (City, town or county) (State) Natrona Heights, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE Ferver Funeral Home		24. ADDRESS Tarentum, Penn.	
25a. REC'D BY REGISTRAR MAX H22, 1961		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	
DATE MAR 20 '61			

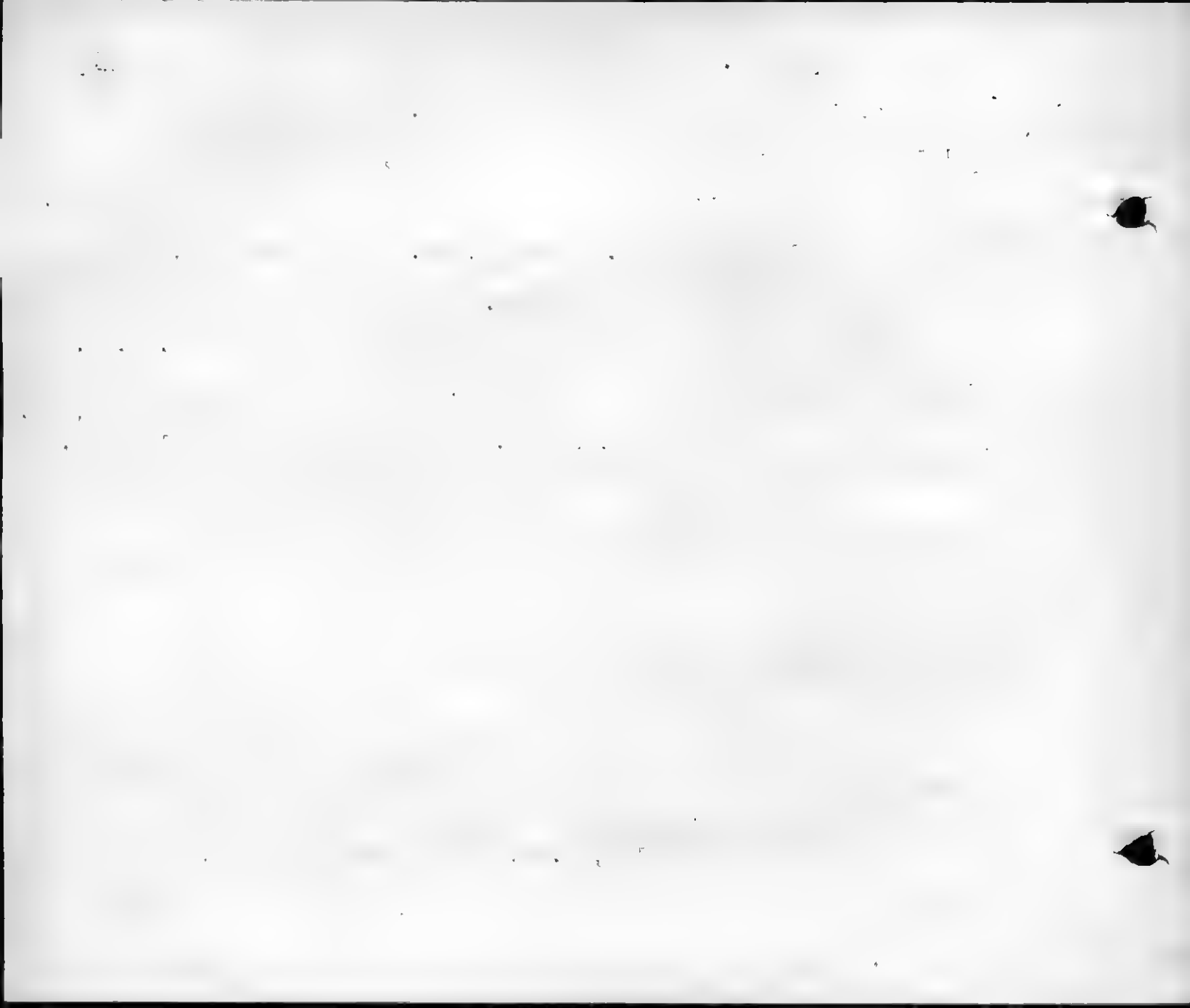


1
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2847

02829

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) b. COUNTY Baltimore Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4946 Tulip Avenue		e. STREET ADDRESS 4946 Tulip Avenue	
3. NAME OF DECEASED (Type or print) First William Middle C. Last Smith, Sr.		4. DATE OF DEATH Month March Day 27 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1891
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Westinghouse		10b. KIND OF BUSINESS OR INDUSTRY Scotland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alexander Smith		14. MOTHER'S MAIDEN NAME Kate McGill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO 034 07 4192	
17. INFORMANT Mrs. Isabella Smith		Address Relay 27, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 163X DUE TO dehydration - due to severe illness Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) hypertension - increasing pressure DUE TO for 6 weeks before time (c) 94 weeks		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1961, to July 25, 1961 , that (I) (we) last saw the deceased alive on July 19, 1961 and that death occurred at 3:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Frederick Beitler		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Frederick Beitler, M. D.		22d. ADDRESS 1014 Francis Avenue, #27	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/29/61	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City, town, or county) (State) Elkridge, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR 4107 Wilkens Avenue	
25b. REGISTRAR'S SIGNATURE DATE MAR 20 '61		25c. REGISTRAR'S SIGNATURE Charles L. Hume	



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2848

Reg. Dist. No. 2830

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dundalk Ymca</u>		d. STREET ADDRESS <u>2007 Inglewood Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>A.</u> Middle <u>Jeanne</u> Last <u>Spittel</u>		4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 8, 1925</u>
9. AGE (In years last birthday) <u>36</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dictaphone Transcriber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hopkins</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry O. Spittel</u>		14. MOTHER'S MAIDEN NAME <u>Alice M. Wicks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(1) yes, give war or dates of service</u>		16. SOCIAL SECURITY NO <u>220224532</u>	
17. INFORMANT <u>Henry O. Spittel</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot Wound (Pistol) Thru</u> <u>976X</u> DUE TO (b) <u>Rt Parietal Region</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Shot Self Thru Rt Temple</u>	
20c. TIME OF INJURY Month, Day, Year <u>3-15-1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>YMCA</u>		20f. City or town (County) (State) <u>Dundalk-Baltimore Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M B Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) <u>M. B. Davis</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3/15/61</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3-18-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Rd.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Funn</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

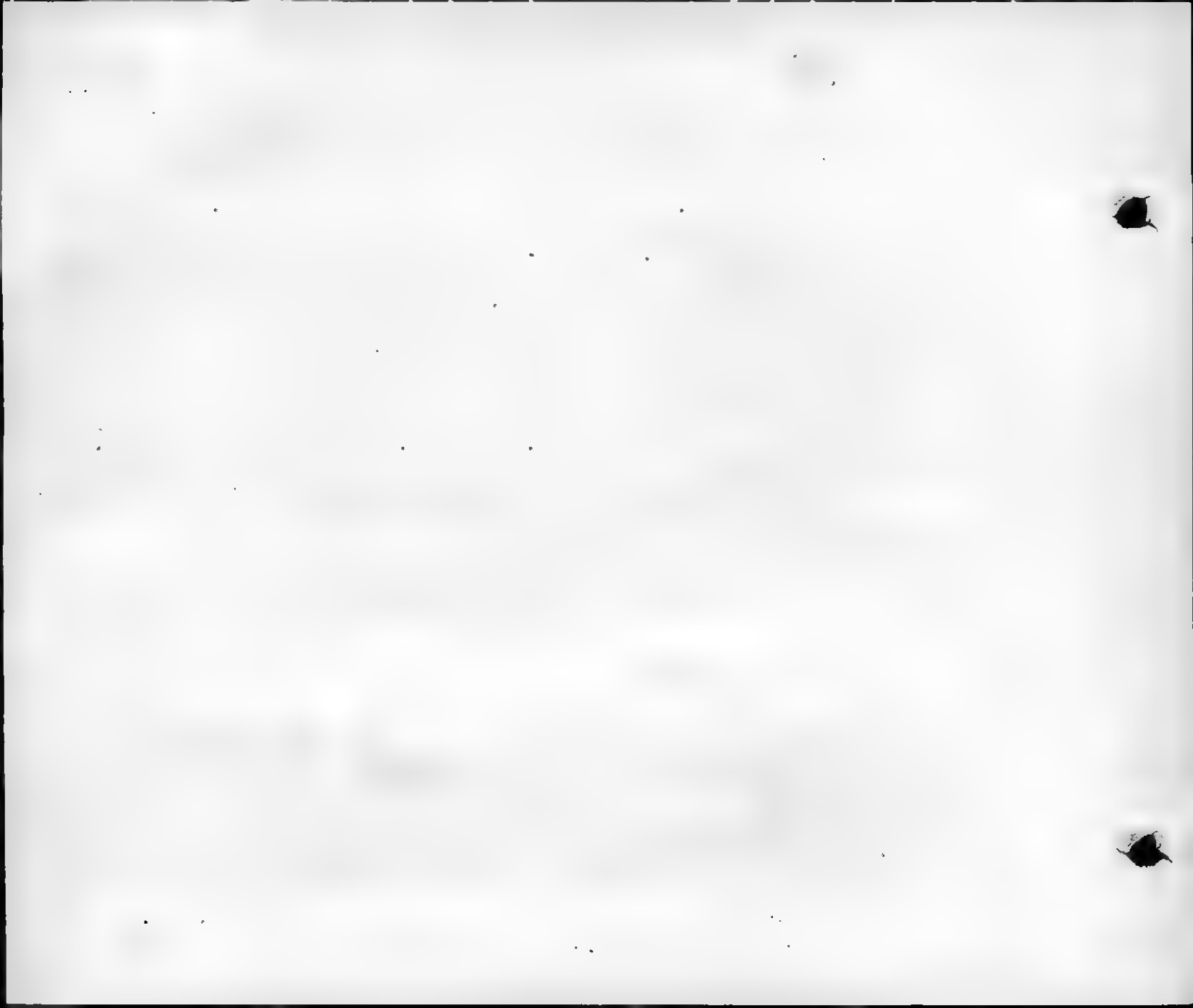
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2849

02831

1 PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 17 Joppa Rd.				d. STREET ADDRESS Box 17 Joppa Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Emanuel A. Middle Stastny Last		4. DATE OF DEATH Month March Day 16, Year 1961					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1890	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist-retired		10b. KIND OF BUSINESS OR INDUSTRY Machine Shop		11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank Stastny			14. MOTHER'S MAIDEN NAME Marie Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-07-4229		17. INFORMANT Address Fullerton, Md Mrs. Rosalie M. Stastny Box 17 Joppa Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-vascular renal. diseas</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>17 years</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1944</u> to <u>Mar 16, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb. 23, 1961</u> , and that death occurred <u>1:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>G. M. Bacon</u>		M D ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>3/17/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>A.M. BACON</u>		22d. ADDRESS <u>2810 Taylor Ave.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF <u>3-18-1961</u>	23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION (City, town, or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 20 '61</u>	25b. REGISTRAR'S SIGNATURE <u>U. Louis G. Evans</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

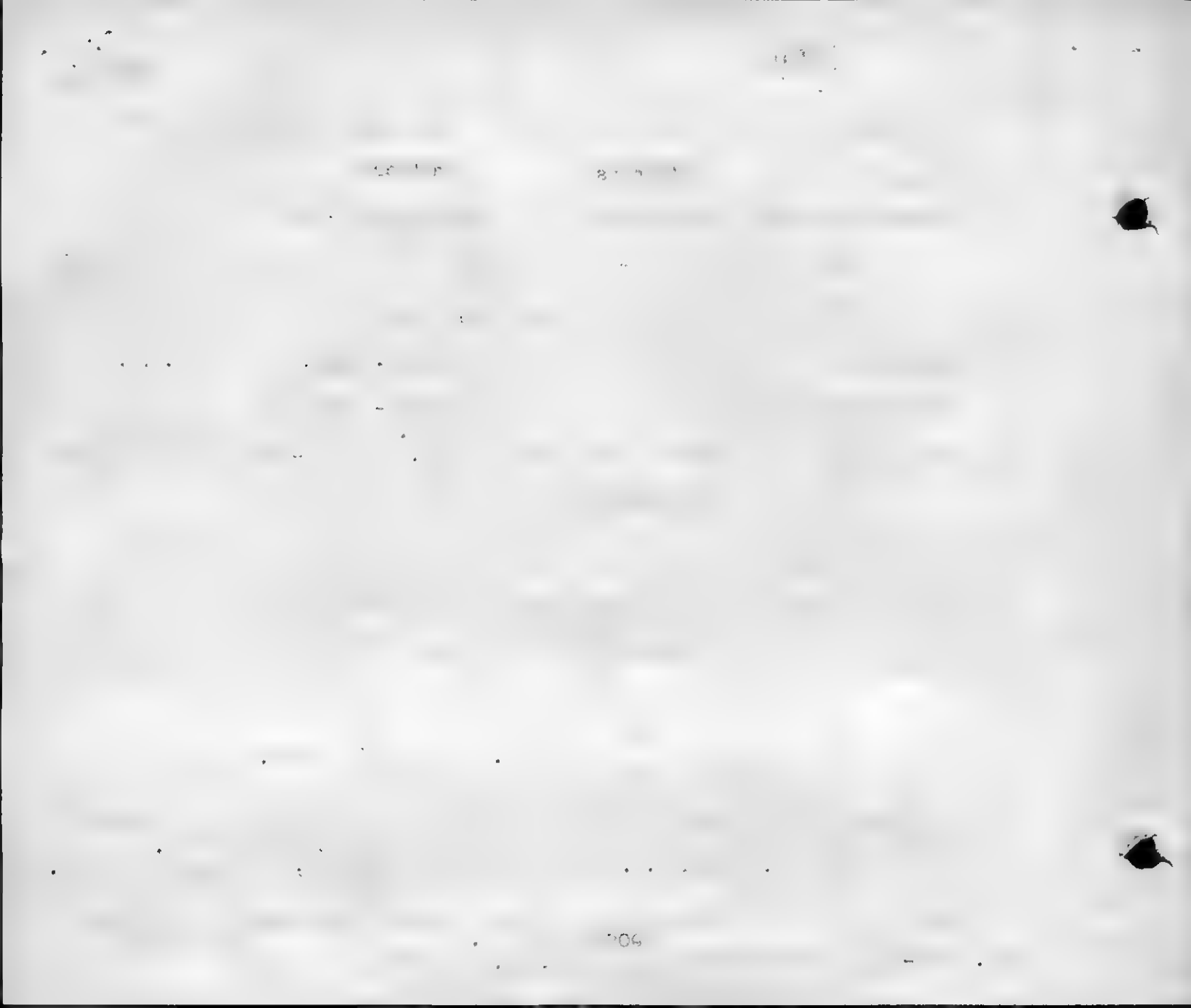
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
2850 CERTIFICATE OF DEATH 02832															
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN IL 22 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hos., give address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Res. before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eastport d. STREET ADDRESS 1017 Madison Street				3. NAME OF DECEASED (Type or print) First WALTER Middle - Last STEIN				4. DATE OF DEATH Month March Day 11 Year 1961			
5. SEX Male				6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH May 27, 1900			
9. AGE (In years last birthday) 60 yrs				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman				10b. KIND OF BUSINESS OR INDUSTRY Highway				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME William Stein				14. MOTHER'S MAIDEN NAME Victoria - Unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-11			
16. SOCIAL SECURITY NO. 218-05-9694				17. INFORMANT Clin. Records				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOSARCOMA 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)				21. I certify that (K (this hospital) attended the deceased from Feb. 17 to Mar. 11 , 1961, that (U) (we) last saw the deceased alive on March 11 , 1961, and that death occurred at 1:45 P.M. from the causes and on the date stated above.				22a. SIGNATURE Joshua A. Smith			
22b. DATE SIGNED 3/11/61				22c. PHYSICIAN'S NAME (Type) JOSHUA A. SMITH, M.D.				22d. ADDRESS 3900 Loch Raven Blvd. VAH, Baltimore 18, Md. Fort Howard Div.				22e. REC'D BY REGISTRAR DATE MAR 15 '61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3-15-61				23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore Maryland				23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Funeral Home				25a. REC'D BY REGISTRAR DATE MAR 15 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				25c. REGISTRAR'S SIGNATURE			

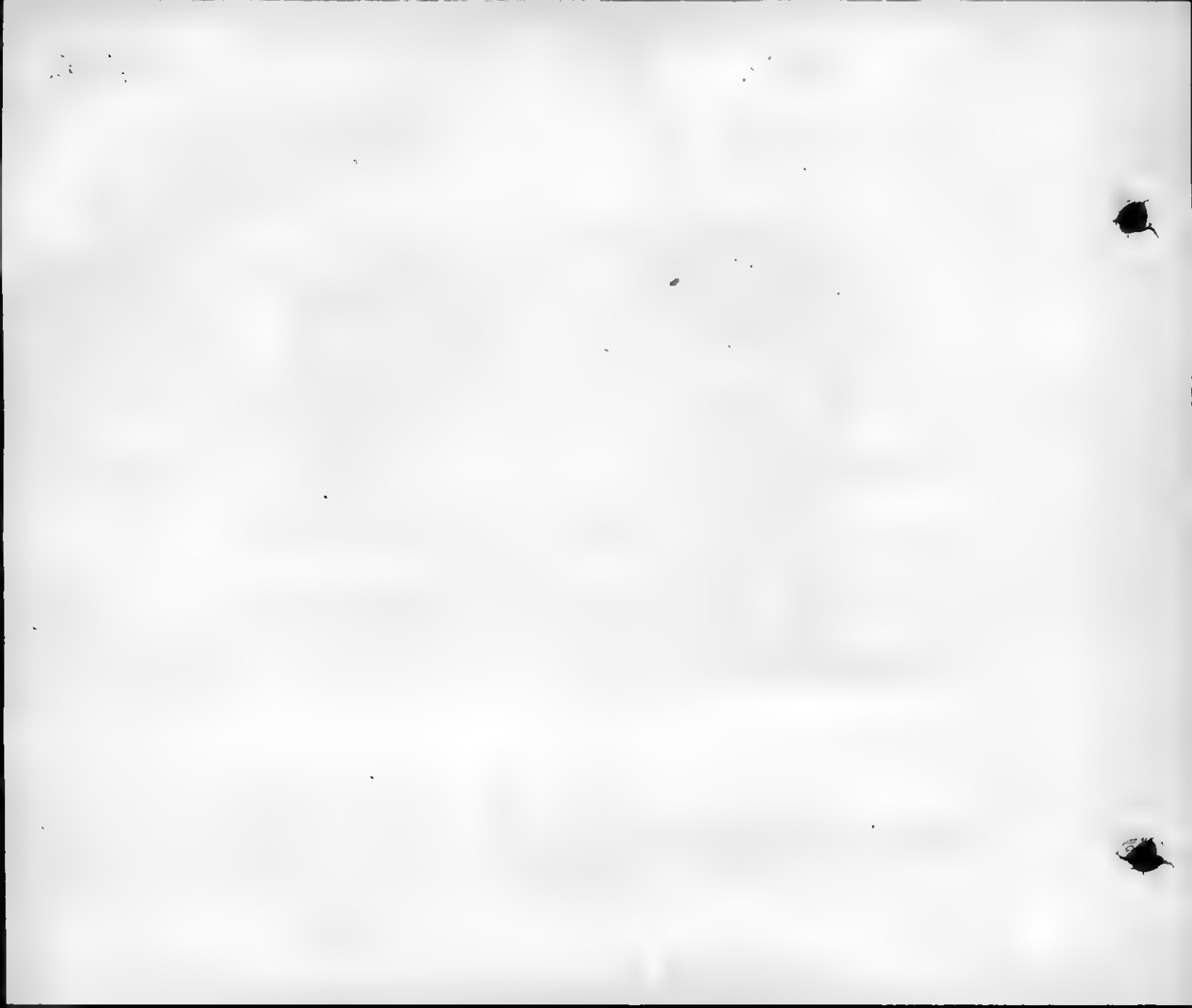


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2851
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02833

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD. b. COUNTY MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOUSE IN PINES, 16 FUSTING AVE.		d. STREET ADDRESS 4600 MANORDENE RD.	
3. NAME OF DECEASED (Type or print) LUDWIG CARL STEINHAGEN		4. DATE OF DEATH MAR. 16, 1961	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 5, 1889
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TRAFFIC ENGINEER, BALTO. TRANSIT		10b. KIND OF BUSINESS OR INDUSTRY GERMANY	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STEINHAGEN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS ETHEL K. STEINHAGEN		Address 4600 MANORDENE RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Hypertension (aortic disease) with coronary artery disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 14 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-23, 1961 , to 3-16, 1961 , that (I) (we) last saw the deceased alive on 3-16, 1961 , and that death occurred at 4:55 PM , from the causes and on the date stated above			
22a. SIGNATURE Wilhelm K. Gallager		22b. DATE SIGNED 3-17-61	
22c. PHYSICIAN'S NAME (Type) Wilhelm K. Gallager, M.D.		22d. ADDRESS 6207 Brooklyn Ave. Baltimore, Md.	
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		23b. DATE THEREOF 3/20/61	
23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMET.		23d. LOCATION (City, town, or county) (State) PIKESVILLE MD.	
24. FUNERAL DIRECTOR'S SIGNATURE WITZKE F.D.		25a. REC'D BY REGISTRAR 4101 EDMONDSON AVE.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE MAR 20 '61	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2852

CERTIFICATE OF DEATH

Reg. Dist. No. 02834

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>812 Register Ave. (Armorest)</u>		d. STREET ADDRESS <u>12X</u>	
3. NAME OF DECEASED (Type or print) First <u>Lily</u> Middle <u>Patterson</u> Last <u>Stier</u>		4. DATE OF DEATH Month <u>March</u> Day <u>14th</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30-1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (In years last birthday) <u>87</u> yrs
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick Ethelred Patterson</u>		14. MOTHER'S MAIDEN NAME <u>Olivia Plaggett Powell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Armorest Nursing Home 812 Register Ave.</u>	
17. INFORMANT <u>Butte twd.</u>		Address <u>Butte twd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>ArterioSclerotic-Cardiac Renal</u> DUE TO <u>Vascular Disease</u> (c) INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>18 yrs</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>OCT 1956</u> , to <u>March 14, 1961</u> , that I last saw the deceased alive on <u>March 14, 1961</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		ADDRESS (Street, city or town, state) <u>7501 York Rd</u> DATE SIGNED <u>3/15/61</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u>		<u>Johnson #4 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/18/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spesantia Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Perryman Harford Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Sarring - Aberdeen, Maryland</u>		24. REC'D BY REGISTRAR <u>MAR 22 61</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
VR A15 (4)
15M 9/60

1
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2853
CERTIFICATE OF DEATH

02835

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>Pyrrildys</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before address on) a. STATE <u>Maryland</u> b. COUNTY <u>1-4</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>925 S. Fremont Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Walter George Stitt</u> 4. DATE OF DEATH <u>March 21 19 61</u>		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 9, 1880</u> 9. AGE (In years last birthday) <u>80</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Sylvester Stitt</u> 14. MOTHER'S MAIDEN NAME <u>Ruth Nofsker</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>unknown</u> 16. SOCIAL SECURITY NO. <u>unknown</u> 17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u> Address <u>U. S. A.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pleural effusion and pulmonary edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease with hypertension</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 10 1959</u> , to <u>March 21 1961</u> , that (I) (we) last saw the deceased alive on <u>March 21 19 61</u> , and that death occurred at <u>1:00</u> M, from the causes and on the date stated above.		22a. SIGNATURE <u>Stella Wachslar</u> M.D. 22b. DATE SIGNED <u>3-21-61</u> 22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u> 22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3/25/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Blairville Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Blairville Pa.</u>		24. FUNERAL OR CREMATION ADDRESS <u>Blairville Pa.</u> 25a. REC'D BY REGISTRAR <u>W. J. H. H. H.</u> 25b. REGISTRAR'S SIGNATURE <u>W. J. H. H. H.</u> DATE <u>MAR 23 '61</u>	



DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2854

02836

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD. b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CATONSVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PARADISE NURSING HOME				e. STREET ADDRESS 1 132 NUNNERY LANE			
3. NAME OF DECEASED (Type or print) First Middle Last LULA E. STYRON				4. DATE OF DEATH Month Day Year MARCH 11 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 20, 1874		9. AGE (In years last birthday) yrs 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN EASTWOOD				14. MOTHER'S MAIDEN NAME ELEANOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO —		17. INFORMANT Joseph Styron - 132 Nunnery Lane			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 hrs 20 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a m p m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 Sept. 1957 to 11 March 1961 , that (I) (we) last saw the deceased alive on 10 March 1961 , and that death occurred at 6 PM , from the causes and on the date stated above.							
22a. SIGNATURE James E. Rowe				22b. DATE SIGNED 14 Mar 61		22c. PHYSICIAN'S NAME (Type) James E. Rowe, M. D.	
22d. ADDRESS 1011 Frederick Rd. Baltimore 28, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial		3-15-61		Truon Park Cem.		Bald Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Foley-Corrough F.H. - Catonsville, Md.				25a. REC'D BY REGISTRAR DATE MAR 17 '61		25b. REGISTRAR'S SIGNATURE William S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2855

CERTIFICATE OF DEATH

02837

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 28</u> c. LENGTH OF STAY IN <u>1 month</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore LaPlata</u> d. STREET ADDRESS <u>Box 301</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Joshua</u> First <u>MA</u> Middle <u>H</u> Last <u>SWANN</u>		4. DATE OF DEATH <u>March 4,</u> 19 <u>61</u>		5. SEX <u>Male</u> <u>White</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 23 1883</u>		9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>				11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Mary Mattingly</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>220 348435</u> 17. INFORMANT <u>Records: Spring Grove State Hospital</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>33</u> DUE TO <u>Cerebral and Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>													
20c. TIME OF INJURY Month, Day, Year <u> </u> Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>					
21. I certify that (I) (this hospital) attended the deceased from <u>2/6/61</u> to <u>3/4/61</u> 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>3/4/61</u> 19 <u> </u> and that death occurred at <u>3</u> P.M. from the causes and on the date stated above.													
22a. SIGNATURE <u>Patrick Ki-Yun Yip</u>				22b. DATE SIGNED <u>MAR 5 1961</u>				22c. PHYSICIAN'S NAME (Type) <u>PATRICK KI-YUN YIP</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL BALTIMORE 28 MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3/7/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's R.C. Cem.</u>		23d. LOCATION (City, town or county) <u>LA PLATA</u>		23e. (State) <u>MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt General Home</u>				24b. ADDRESS <u>Waldorf Md.</u>		25a. REC'D BY REGISTRAR <u>DAT MAR 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

2856

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

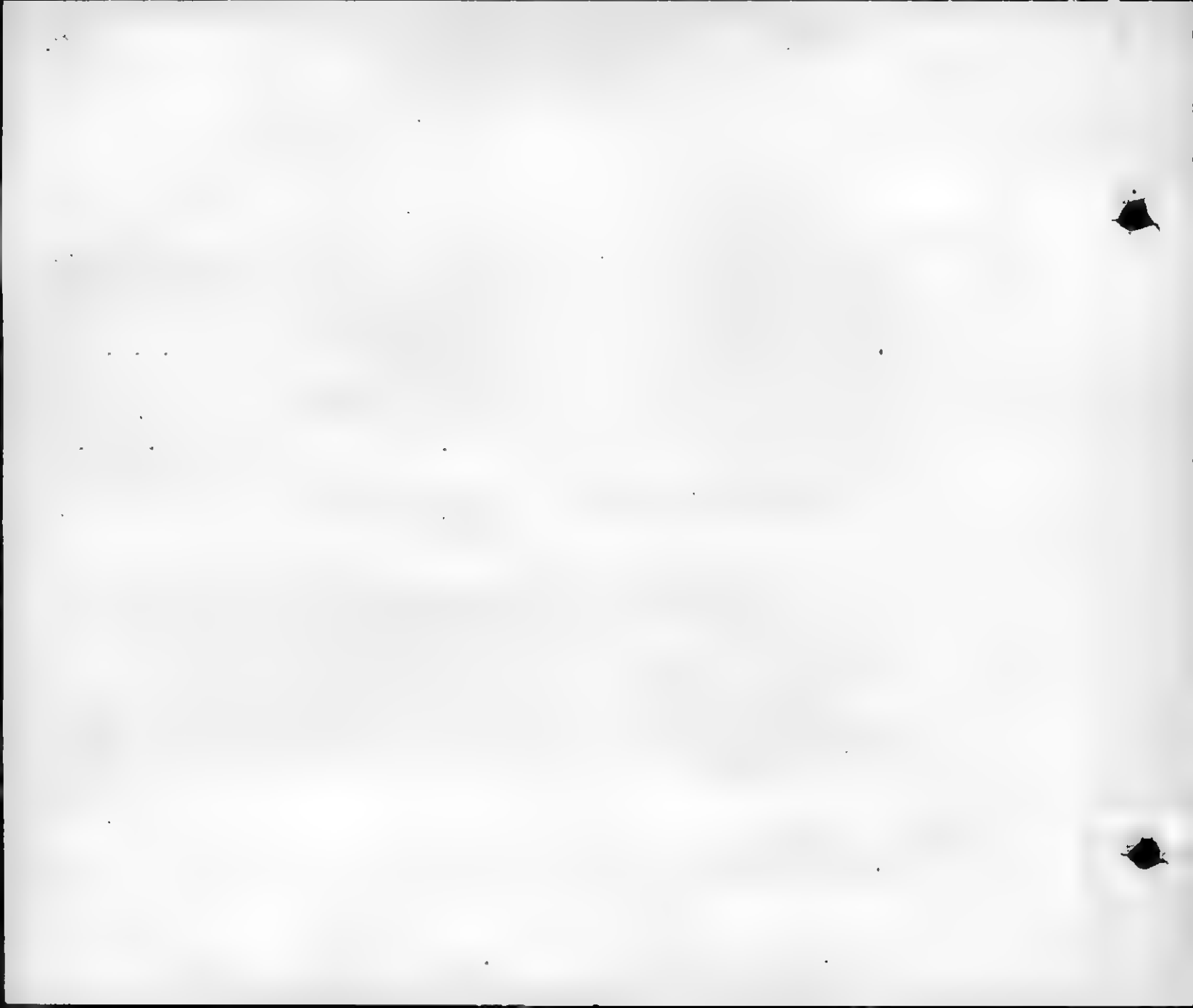
CERTIFICATE OF DEATH

02838

Item 23 d, 11-10-61

3/24/61 iwr

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Byway Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth Long Talbert		4. DATE OF DEATH Month 3 - 16 - 1961 Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-21-1884
9. AGE (In years lost birthday) 76 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Long		14. MOTHER'S MAIDEN NAME Minnie Rannader	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Robert L. Talbert		Address Owings Mills 15 Byway Rd. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis Arteriosclerotic C-V Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.		20d. INJURY OCCURRED While o. m. <input type="checkbox"/> Not while o. m. <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that (I) the physician attended the deceased from 12-26-39 to 3-16-61 , 19____, that (I) was last saw the deceased alive on 3-16-61 , 19____, and that death occurred at 10:30AM , from the causes and on the date stated above.			
22a. SIGNATURE D. D. Caples		22b. DATE SIGNED 3-18-61	
22c. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		22d. ADDRESS 6 Hanover Rd., Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-20-61	
23c. NAME OF CEMETERY OR CREMATORY Grace Methodist		23d. LOCATION (City, town, or county) (State) Cockeysville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service		25a. REC'D BY REGISTRAR MAR 21 '61	
ADDRESS Towson 4, Md.		25b. REG. STRAR'S SIGNATURE Arthur S. Kraus	



CERTIFICATE OF DEATH

Reg. Dist. No.

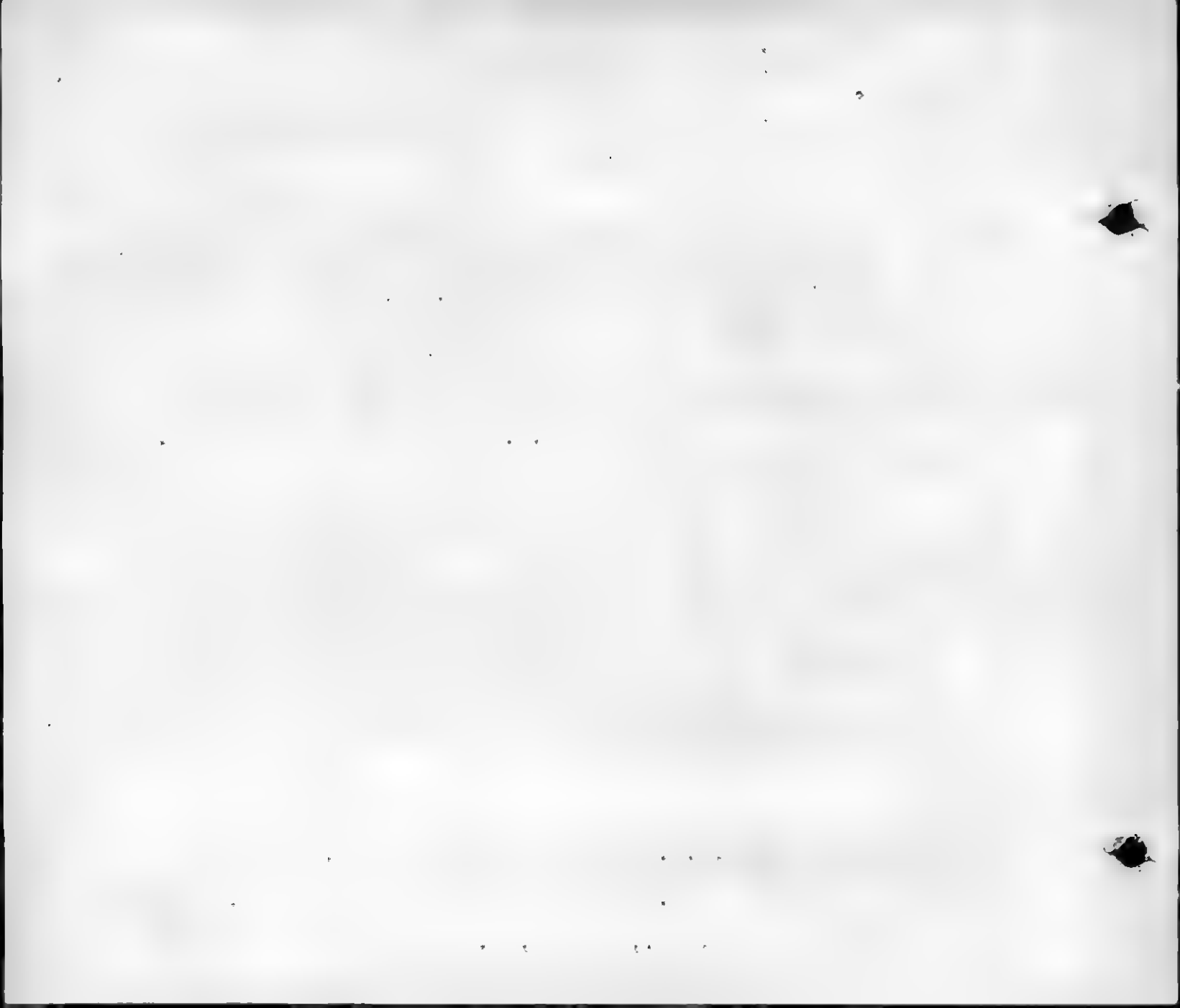
02839

2857

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. LENGTH OF STAY IN 1b 43 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 229 Patapsco Avenue		d. STREET ADDRESS 229 Patapsco Avenue	
3. NAME OF DECEASED (Type or print) First LIA Middle LOUISE Last TAMASSIA		4. DATE OF DEATH Month March Day 22nd Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1882
9. AGE (In years last birthday) 78 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy ✓	
13. FATHER'S NAME Peter Rossi		14. MOTHER'S MAIDEN NAME ??? Bertazza	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none	
17. INFORMANT H.V. Tamassia, 30 Bangert Ave., Fullerton		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 444X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Hypertension Cardiovascular Disease DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-7-1951 to 3-22-1961 , that I last saw the deceased alive on 3-22-1961 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Eugene F. Nevy M.D. 7001 Morningside Road 3/24/61 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Eugene Nevy, M.D. Baltimore 22, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/25/61	
22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk, Md.		24a. REC'D BY REGISTRAR DATE MAR 27 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2858 CERTIFICATE OF DEATH 02840											
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTO. 12 c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 524 CASTLE DRIVE				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MD. b. COUNTY BALTO. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTO. 12 d. STREET ADDRESS 524 CASTLE DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ALICE V. TATUM				4. DATE OF DEATH Month MARCH Day 30 Year 1961							
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 27, 1871		9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL HOLMES				14. MOTHER'S MAIDEN NAME HANNA LAIFF							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO				16. SOCIAL SECURITY NO. -				17. INFORMANT MRS. DOROTHY T. HERRLICH Address ABOVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ENCEPHALIC MALIG. DUE TO Conditions, if any, which gave rise to immediate cause (b) GENERALIZED ARTERIO SCLEROSIS (c) 1: f- DUE TO cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from MARCH 19, 1961 to MARCH 30, 1961 , that (I) (we) last saw the deceased alive on MARCH 19, 1961 , and that death occurred at 10:00 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Frederick J. Jenkins M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED MAR 31, 1961			
22c. PHYSICIAN'S NAME (Type) FREDERICK J. JENKINS				22d. ADDRESS 6100 YORK RD, BALTO. 12 MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 4-3-61				23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL			
23d. LOCATION (City, town or county) BALTO.				(State) MD							
24. FUNERAL DIRECTOR'S SIGNATURE H.W. JENKINS & SONS CO. 4905 YORK ROAD				ADDRESS				25a. REC'D BY REGISTRAR APR 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2859

Items 13 & 14 film 0284 4/5/61 JWA

02841

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House In Pines, 16 Fusting Ave.		d. STREET ADDRESS 5105 Edmondson Ave	
3. NAME OF DECEASED (Type or print) John J. Tatum		4. DATE OF DEATH Month Day Year March 28/61 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1866
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 94 yrs.
11. BIRTHPLACE (County & State, or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Tatum	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Chauncey R. Tatum, 5105 Edmondson Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Insufficiency			
Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic cardio vascular disease			
cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 11, 1943, to March 28, 1961 , that (I) (we) last saw the deceased alive on March 28, 1961 , and that death occurred 2:25 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>George A. Knipp</i>		22b. DATE SIGNED Mar. 29, 1961	
22c. PHYSICIAN'S NAME (Type) George A. Knipp, M. D.		22d. ADDRESS 4116 Edmondson Avenue	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/30/61	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town or county) (State) Baltimore 29, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D.		25a. REC'D BY REGISTRAR DATE MAR 30 '61	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

2860

2842

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco (Rural) 2		c. LENGTH OF STAY IN 1b 50 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Upperco (Rural)	
3. NAME OF DECEASED (Type or print) CHARLES REVERDY TAWNEY		4. DATE OF DEATH Month Day Year Mar. 13 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 25, 1888
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Tawney		14. MOTHER'S MAIDEN NAME Agnes Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. 218-32-5118	
17. INFORMANT Charles T. Tawney, Upperco, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angina Pectoris 120.2 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ none		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year none 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
20e. (City or town) none		20f. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE D. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-16-61	
22c. NAME OF CEMETERY OR CREMATORY Trenton		22d. LOCATION (City, town, or country) (State) Balto. Co. Md.	
23. FUNERAL DIRECTOR ADDRESS Edward C. Tipton, Hampstead, Md.		24a. REC'D BY REGISTRAR DATE MAR 20 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2862

CERTIFICATE OF DEATH

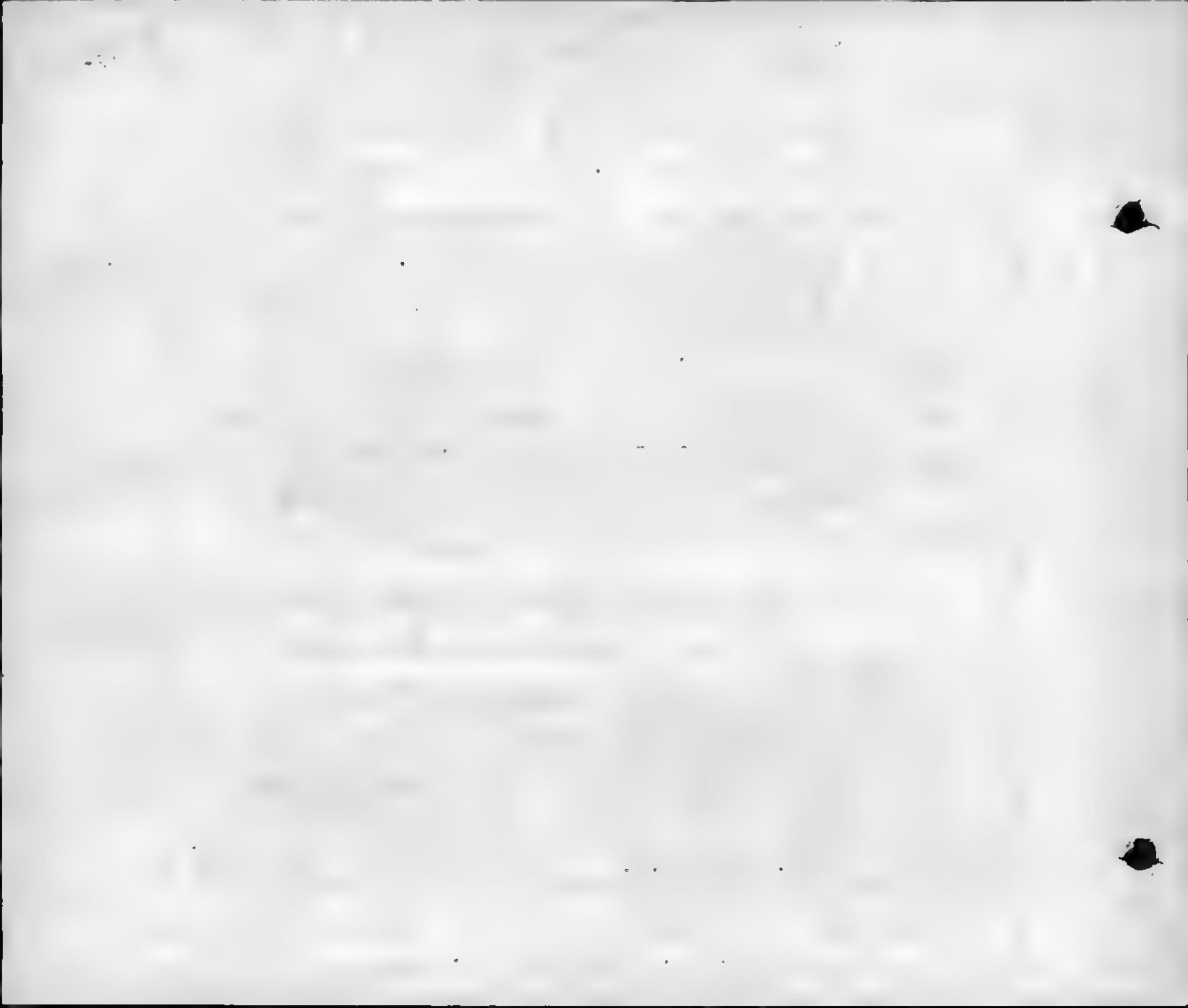
Reg. Dist. No.

02844

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)			c. LENGTH OF STAY IN 1b one yr.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 122 Kinship Road			e. STREET ADDRESS 122 Kinship Road		
3. NAME OF DECEASED (Type or print) First Middle Last JAMES FRANKLIN TIMMONS, Sr.			4. DATE OF DEATH Month Day Year March 2nd, 1961		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1894	9. AGE (In years last birthday) 66 yrs	10. IF UNDER 1 YEAR: Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY Wh. Meat		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Thomas Timmons		
14. MOTHER'S MAIDEN NAME Sarah Carr			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes WWI		
16. SOCIAL SECURITY NO. 215-09-9489			17. INFORMANT Sarah L. Timmons Address same as #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) myocarditis (acute)					INTERVAL BETWEEN ONSET AND DEATH 10 1/2 hr 5 hr 1 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Feb - 1, 1961		20g. (County) MAR 2, 1961		20h. (State) 1961	
21. I certify that I attended the deceased from Feb - 1, 1961 to MAR 2, 1961 , that I last saw the deceased alive on MAR 1, 1961 , and that death occurred at 3:00 A. M. from the causes and on the date stated above.					
ACTUAL SIGNATURE David H. Andrew			ADDRESS (Street, city or town, state) 33 Dundalk Avenue DATE SIGNED 3/3/61		
PHYSICIAN'S NAME (Type) David H. Andrew, M.D.			ADDRESS Baltimore 22, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/61		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
22d. LOCATION (City, town, or county) Baltimore, Maryland		22e. (State) Maryland		22f. (Country) USA	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Prooks Bradley, Inc., Dundalk 22, Md			24. REC'D BY REGISTRAR MAR 6 '61		
24b. REGISTRAR'S SIGNATURE Arthur P. K...			24c. (City or town) Baltimore		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

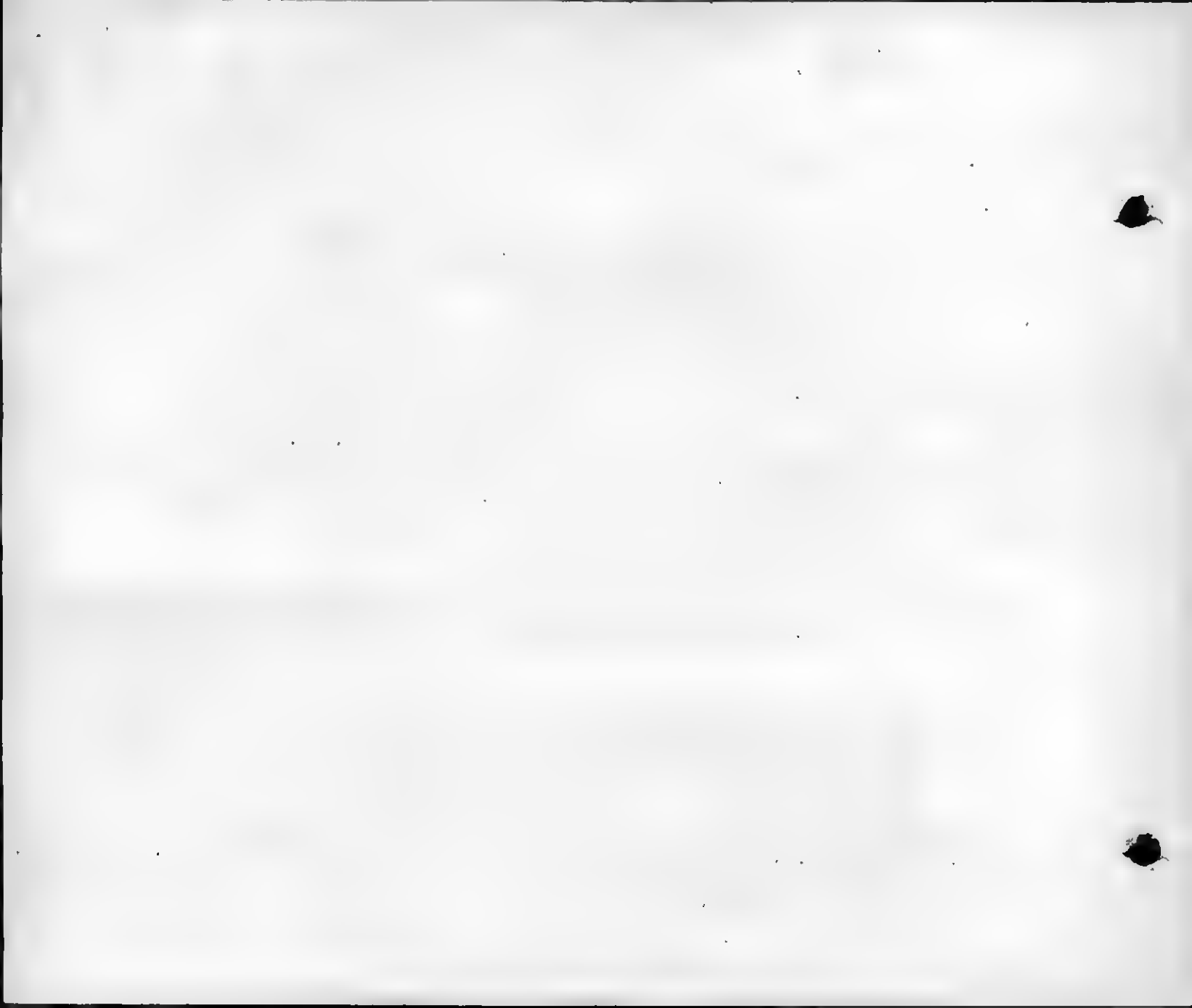
2863

CERTIFICATE OF DEATH

02845

Items 23c & d, 23m 3204 4/10/61 iwk

1 PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b. STATE Maryland		b. COUNTY Pr. Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 5 mo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) Mt. Wilson State Hospital				d. STREET ADDRESS 420 57 th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First EVERETT		Middle WILLIAM		Last TOMLINSON		4. DATE OF DEATH Month 3 Day 28 Year 1961	
5. SEX M	6. COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8.21.1908		9 AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME BERNARD TOMLINSON				14 MOTHER'S MAIDEN NAME VIRGINIA SMITH			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO (If yes, give year or dates of service) Unknown		17 INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 15 min.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 10-11-1960 to 3-28-1961, that (I) (we) last saw the deceased alive on 3-28-1961, and that death occurred at 7:05 AM from the causes and on the date stated above							
22a. SIGNATURE W. Ne Comer, M.D., Superintendent				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 3.31.1961	
22c. PHYSICIAN'S NAME (Type) Wm. Ne Comer, M.D., Superintendent				22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF April 4 1961		23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Howell				25a. REGISTRAR'S SIGNATURE DATE APR 5 '61		25b. REGISTRAR'S SIGNATURE 12.1.1961	



CERTIFICATE OF DEATH

Reg. Dist. No.

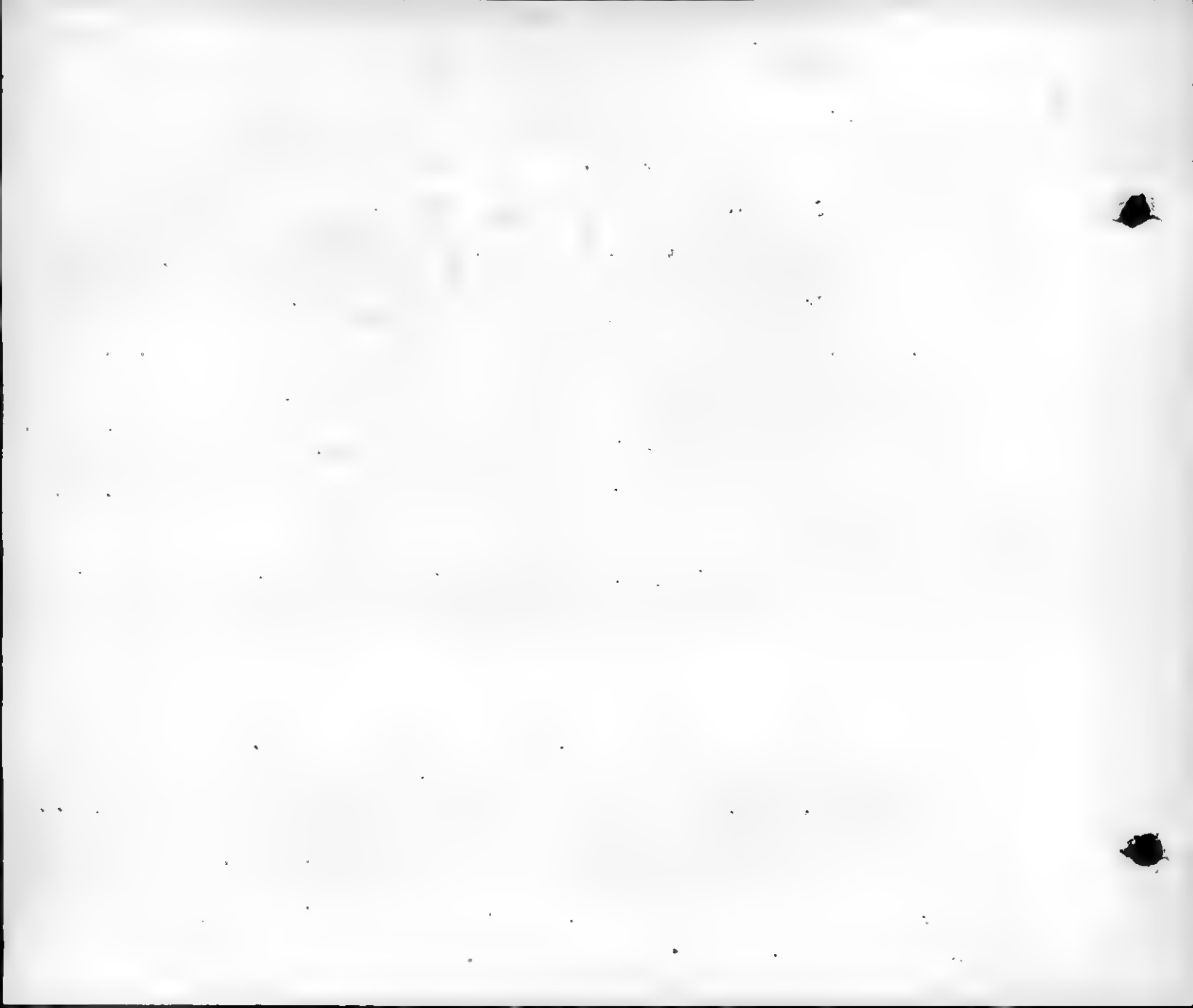
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1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 71 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 334 Oella Avenue				d. STREET ADDRESS 334 Oella Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle William Last Treuth				4. DATE OF DEATH Month March Day 3 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1889		9. AGE (In years last birthday) 71 yrs	IF UNDER 1 YEAR Months 71 Days 0 Hours 0 Min 0	IF UNDER 24 HRS. Hours 0 Min 0 Sec 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Packing		10b. KIND OF BUSINESS OR INDUSTRY Owner of Business		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles William Treuth				14. MOTHER'S MAIDEN NAME Mary A. Keiner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-4006		Address Catonsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Intense Chronic Pulmonary Disease DUE TO (c) Diabetes Mellitus PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							INTERVAL BETWEEN ONSET AND DEATH 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 10, 1958 to March 3, 1961 , that I last saw the deceased alive on February 28, 1961 , and that death occurred at 8 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William F. Cassaway M.D.				ADDRESS (Street, city or town, state) Ellicott City, Md. DATE SIGNED 3/3/61			
PHYSICIAN'S NAME (Type) Dr. William F. Cassaway				Ellicott City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 3/6/61		22c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gaston H. ...				ADDRESS Catonsville, Md.		24a. REC'D BY REGISTRAR DATE MAR 8 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

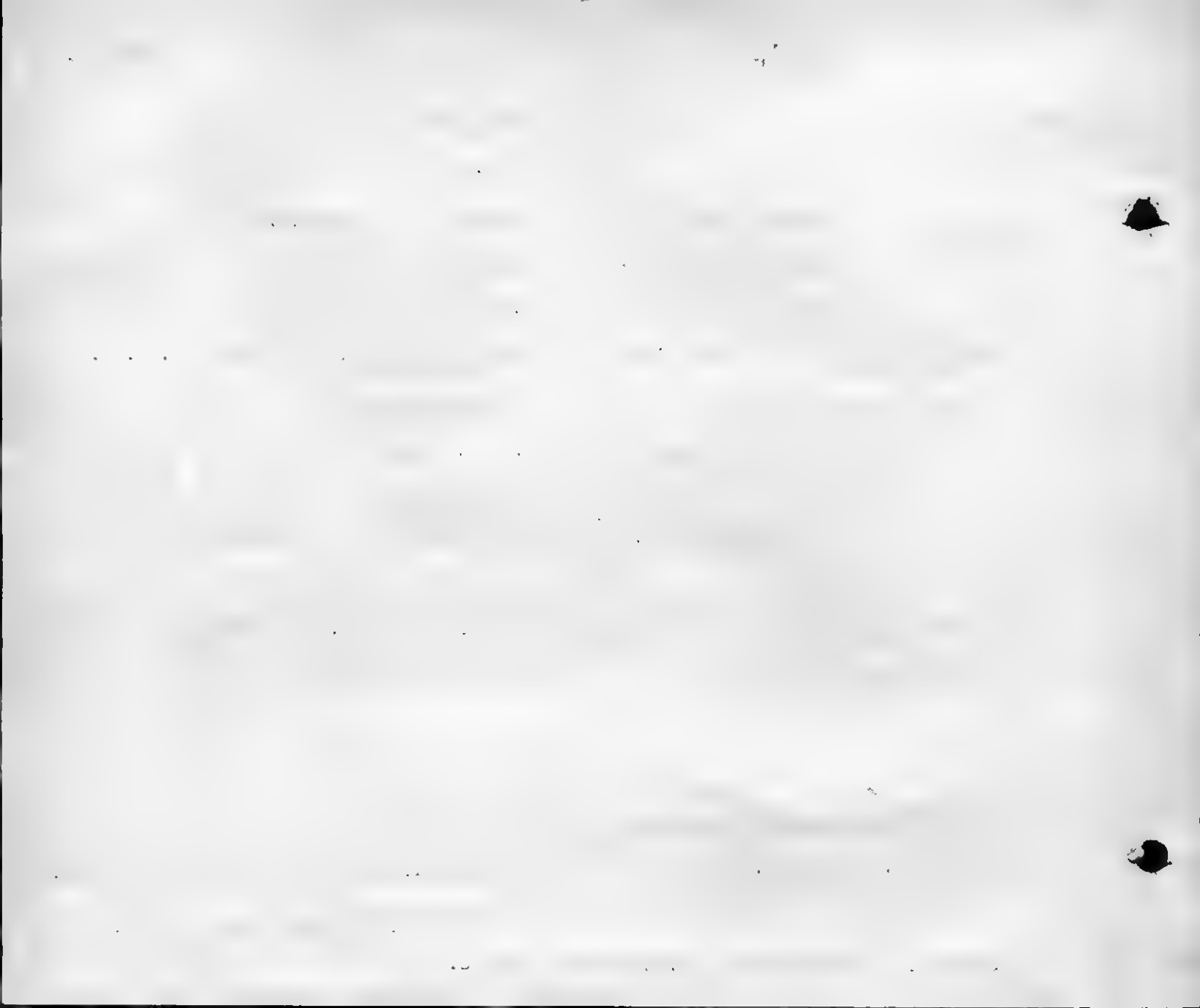


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours after death, the law requires that the death certificate be executed within 24 hours after death. If 24 hours after death, the law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
2865 02847											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institut on; Residence before adm ssion) a. STATE Maryland b. COUNTY Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (408 Pitman Place) Baltimore 2, Maryland d. STREET ADDRESS 408 Pitman Place (2)							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland				c. LENGTH OF STAY IN b 106 Days				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				f. DATE OF DEATH Last First Middle March 14 1961				g. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
3. NAME OF DECEASED (Type or print) GEORGE Z. TURNER				8. DATE OF BIRTH 4/13/94				9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
5. SEX Male				6. COLOR OR RACE Colored				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Co., Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George Robinson				14. MOTHER'S MAIDEN NAME Liddy MN: Unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I			
16. SOCIAL SECURITY NO 217-32-9462				17. INFORMANT CLin. Rec., VAH, Baltimore 18, Md., Ft. Howard Div.,				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO PYELONEPHRITIS AND PYONEPHROSIS Conditions, if any, which gave rise to immediate cause (b) CARCINOMA, BLADDER WITH METASTASIS TO MESENTERIC & ILIAC LYMPH NODES (c) & ILIAC LYMPH NODES			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20. TIME OF INJURY Hour a.m. p.m. 19				21. I certify that (X) (this hospital) attended the deceased from November 28, 1960 , to March 14, 1961 , that (Y) (we) last saw the deceased alive on March 14, 1961 , and that death occurred at 6:40 M, from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan				22b. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD, DIVISION				23. LOCATION (City, town or county) (State) Baltimore 2, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Charles B. Lewis Mortuary, 1639 N. Broadway, Balto 13, Md.				25. REC'D BY REGISTRAR MAR 15 '61				26. REGISTRAR'S SIGNATURE Charles B. Lewis			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2866
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02848

Items 23a, b, c & d Film G283 3/20/61 iwk

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 35yr 25dys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 729 Montford Avenue (S)	
3. NAME OF DECEASED (Type or print) Julia Schulland Tyma		4. DATE OF DEATH March 5 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH April 12, 1882	9. AGE (In years last birthday) 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress		10b. KIND OF BUSINESS OR INDUSTRY tailor shop	11. BIRTHPLACE (County & State, or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY? Poland		13. FATHER'S NAME Matthew Tyma	
14. MOTHER'S MAIDEN NAME Mary Salboszeka		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cardiac failure DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) long standing (c) Interval between onset and death 3 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) long standing			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year July 1 1955 20d. INJURY OCCURRED 8:45 p.m. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) March 5 1961 20f. (City or town) Baltimore (County) Md. (State)			
21. I certify that (I) (this hospital) attended the deceased from July 1 1955 to March 5 1961 that (I) (we) last saw the deceased alive on March 5 1961 , and that death occurred at 8:45 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachler		22b. DATE SIGNED 3-5-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachler, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/11/61	
23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		23d. LOCATION (City, town or county) Baltimore Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Kaczorowski Fun. Serv. 1515 Hub St. Baltimore Md.		25a. REC'D BY REGISTRAR MAR 13 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

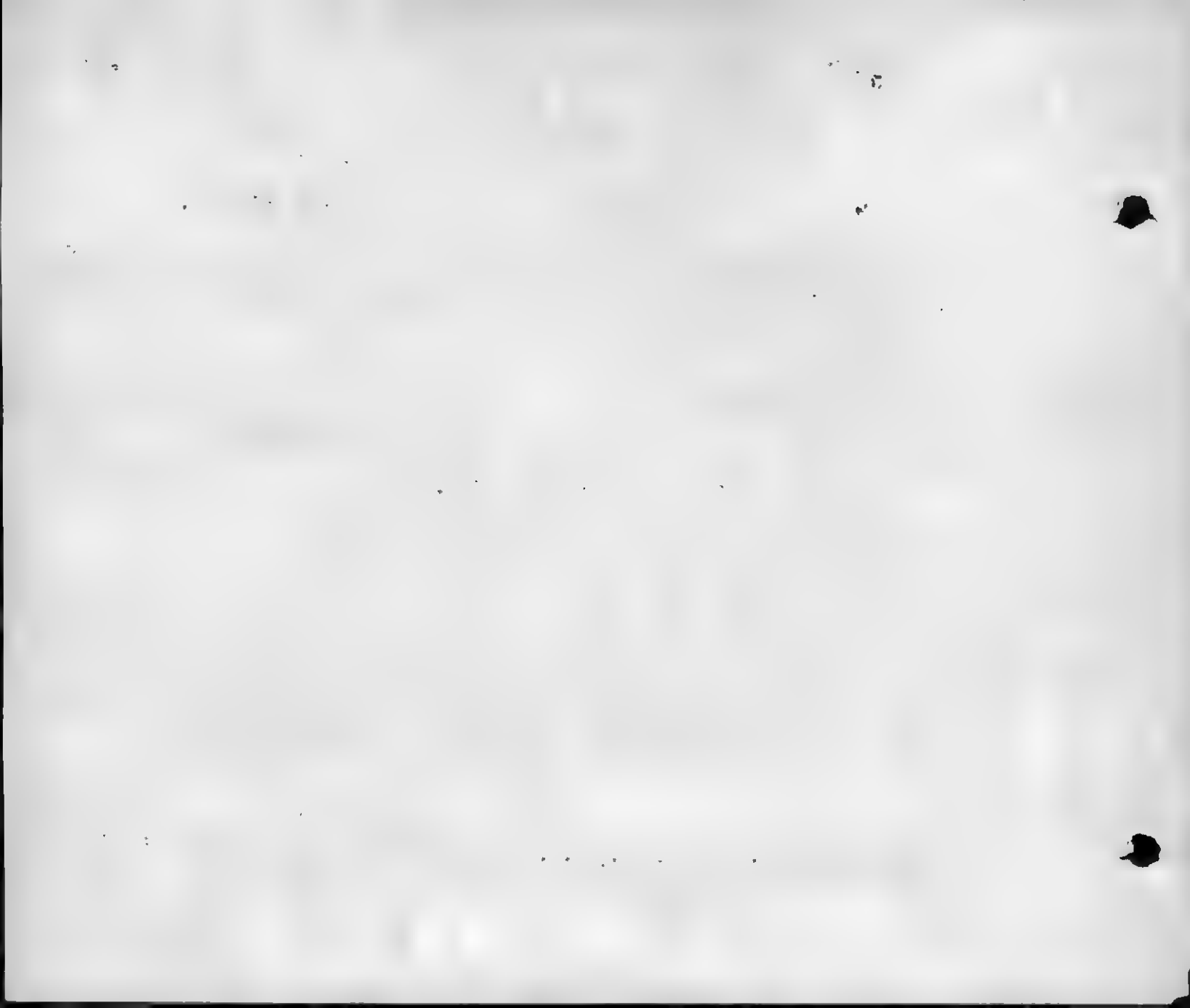


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1216 LANDINGTON AVE.				d. STREET ADDRESS LANDINGTON 1216 Landington Ave.			
3. NAME OF DECEASED (Type or print) Stanley UDES				4. DATE OF DEATH Month March Day 18 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 9, 1911	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 49 Days 49		IF UNDER 24 HRS. Hours 49 Min. 49		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY CONTRACTOR		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME CHARLES UDES				14. MOTHER'S MAIDEN NAME MARY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. WW II			
17. INFORMANT Mrs. Catherine M. Udes - 1216 Landington Rd				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning. 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. (c) } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Inhalation of carbon monoxide			
20c. TIME OF INJURY Month, Day, Year 6:45 p.m. 3/18 1961				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) car	
20f. (City or town) Baltimore				(County) Baltimore (State) MD.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inquire <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 18, 1961 Address (Street, city, town, or county)							
ACTUAL SIGNATURE William V. Lovitt, Jr., M.D.				EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-22-61		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.	
22d. LOCATION (City, town, or country) Baltimore				(State) MD.			
23. FUNERAL DIRECTOR Wm. Cronan & F.H. - Catonsville, Md.				ADDRESS			
24a. REC'D BY REGISTRAR MAR 24 '61				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			



1
FOR STATE
HEALTH DEPT.

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If a physician is necessary, he should execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

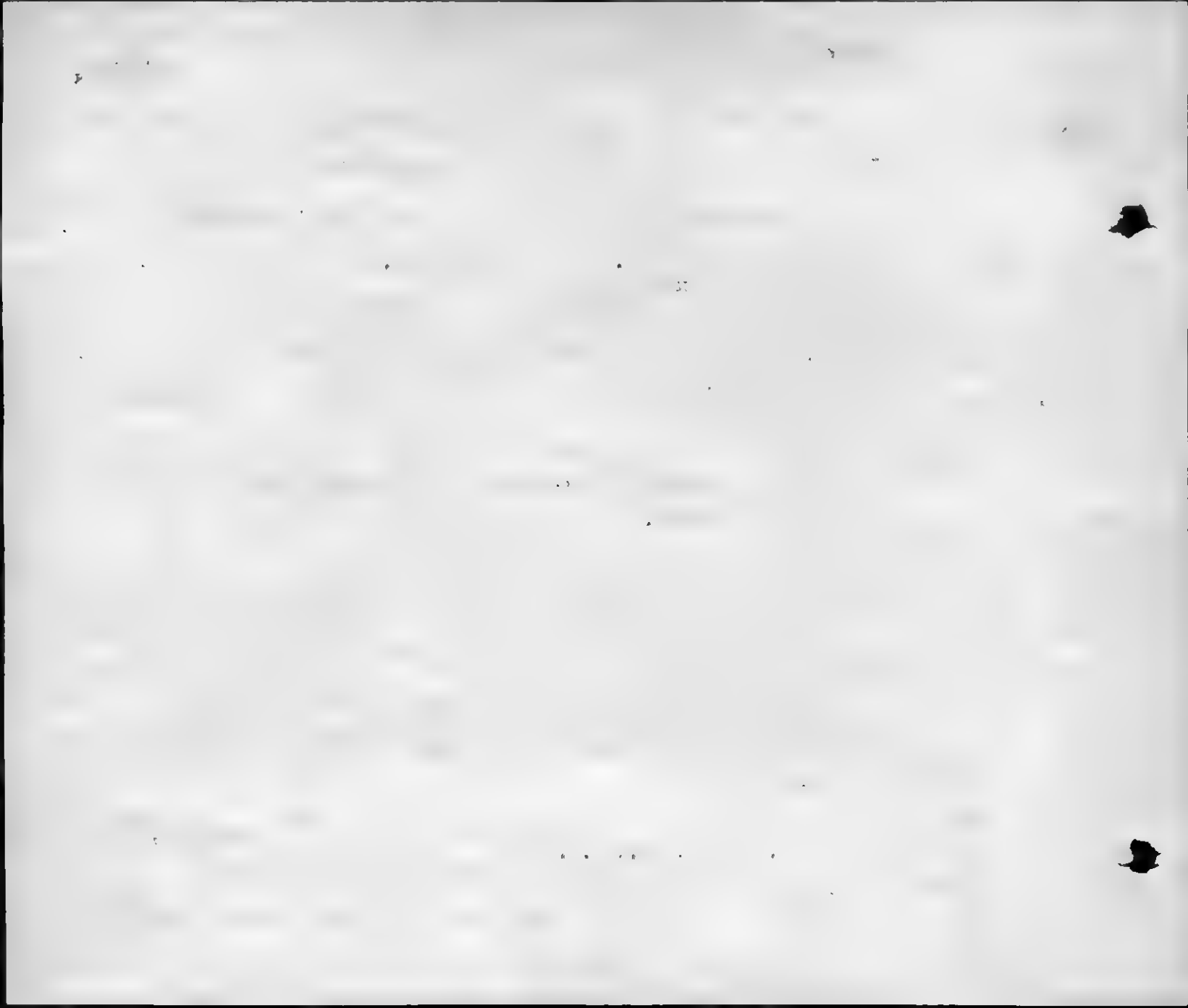
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2868 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02850

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if not full on: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON				c. LENGTH OF STAY IN 1b Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 523 Goucher Blvd				d. STREET ADDRESS 523 Goucher Boulevard			
3. NAME OF DECEASED (Type or print) John L. WALTERS, Jr.				4. DATE OF DEATH March 23, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 5-11-1910	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CROWN-CORK-&Seal Co		10b. KIND OF BUSINESS OR INDUSTRY TOWSON, Md		9. AGE (In years last birthday) 50 yrs.		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME John L. WALTERS, Sr				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO				16. SOCIAL SECURITY NO. 5-11-1910			
17. INFORMANT Mrs Alice M. Baker				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction of interventricular septum. 420.1 MI Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 420.1			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE William N. Lovitt, Jr., M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William N. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) 3-28-61				22b. DATE THEREOF 3-28-61			
22c. NAME OF CEMETERY OR CREMATORY MORCLAND PK				22d. LOCATION (City, town, or country) (State) BALTO MD			
23. FUNERAL DIRECTOR Lernard J Ruck 5305 Hayford				24a. REC'D BY REGISTRAR MAR 27 '61			
24b. REGISTRAR'S SIGNATURE Arthur S. Kline				DATE SIGNED March 24, 1961			

MEDICAL CERTIFICATION



1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

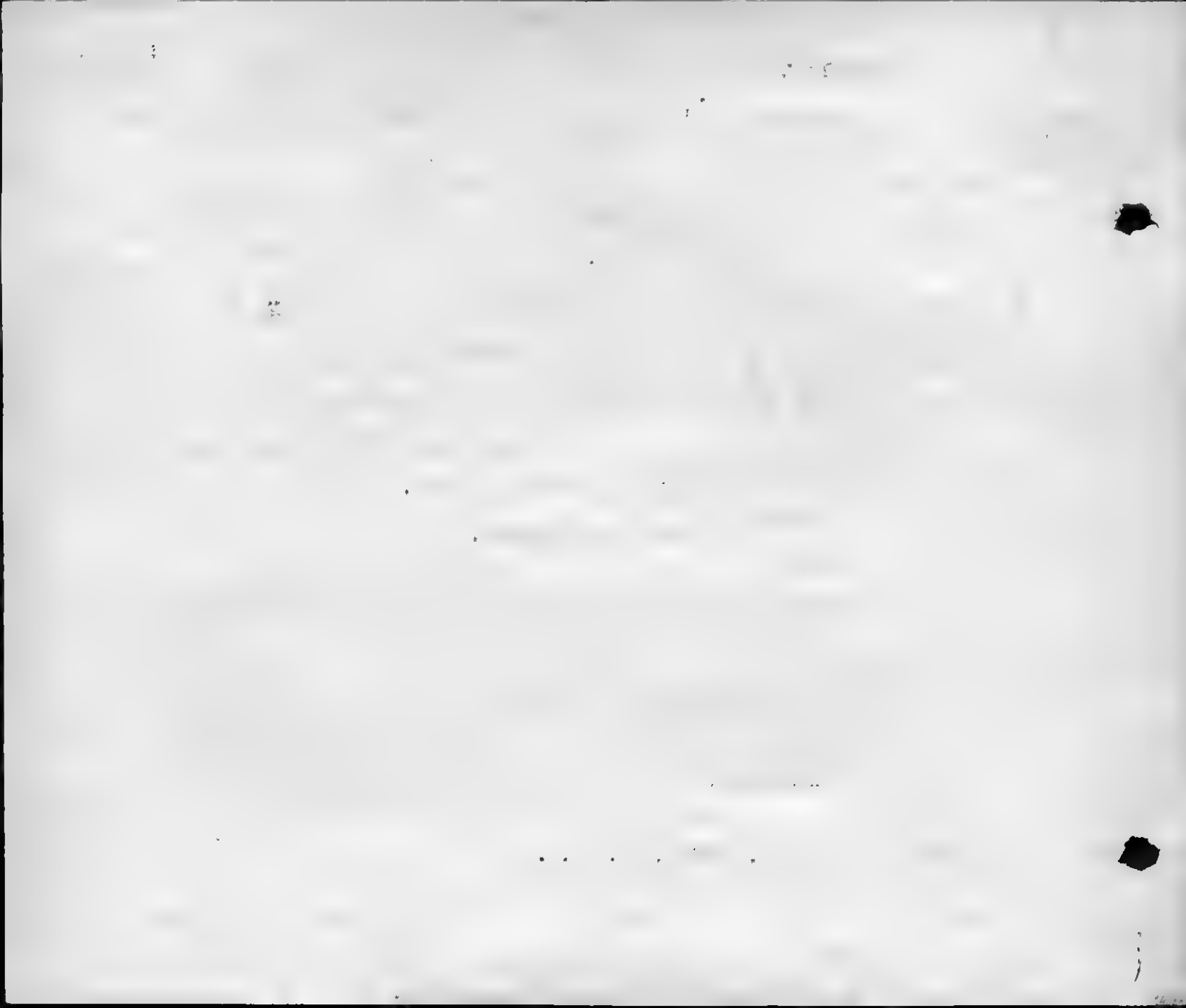
VS. A15ME
5M 7/59

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2869 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02851									
1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		Maryland-	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		523 Goucher Blvd.		d. STREET ADDRESS		523 Goucher Boulevard		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		MILDRED B. WALTERS		4. DATE OF DEATH		March 23, 1961		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		Female		6. COLOR OR RACE		White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Medical Secretary		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		Charles Edward Bevans		14. MOTHER'S MAIDEN NAME		M. Eleanor Handers		USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		1718 E 29th ST.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis. 201 XXXX Coronary Insufficiency. Conc ans, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED March 24, 1961	
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		William V. Lovitt, Jr., M.D.		Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
Burial		3/28/61		Moreland Mem.		BALTIMORE, Md.			
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REG STRAR		24b. REGISTRAR'S SIGNATURE			
L. J. Ruck		5305 HARFORD RD.		DATE MAR 27 '61		O. B. S. H. H. H.			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2870

CERTIFICATE OF DEATH

Reg. Dist. No. 02852

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparks</i>		c. LENGTH OF STAY IN 1b <i>80 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparks</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Quaker Bottom Rd #1</i>				d. STREET ADDRESS <i>Quaker Bottom Rd #1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>Watkins</i> Last <i>Watkins</i>				4. DATE OF DEATH Month <i>March</i> Day <i>21</i> Year <i>1961</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>C</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>14 February, 1876</i>	
9. AGE (In years last birthday) <i>85</i> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labourer</i>		11. BIRTHPLACE (State or foreign country) <i>Pretty Boy Town area</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>UNKNOWN</i>				14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Daughter <i>Ellen Dorsey</i> Address <i>Same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arterio-sclerotic cardiac vascular disease</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>15 years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1946 to March, 1961</i> , that I last saw the deceased alive on <i>2 March, 1961</i> , and that death occurred at <i>9:30 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Cockeysville Maryland</i> DATE SIGNED <i>21 March 1961</i> ACTUAL SIGNATURE <i>Walter T. Kees</i> M.D. PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>3-24-1961</i>		22c. NAME OF CEMETERY OR CREMATORY <i>STEVENSON A. M. E.</i>		22d. LOCATION (City, town, or county) (State) <i>SPARKS, MARYLAND</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>WILLIAM A. JACKSON FUNERAL HOME</i>				24a. REC'D BY REGISTRAR <i>916 PENNA. AVE</i> DATE <i>MAR 23 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Wm. S. Hump</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

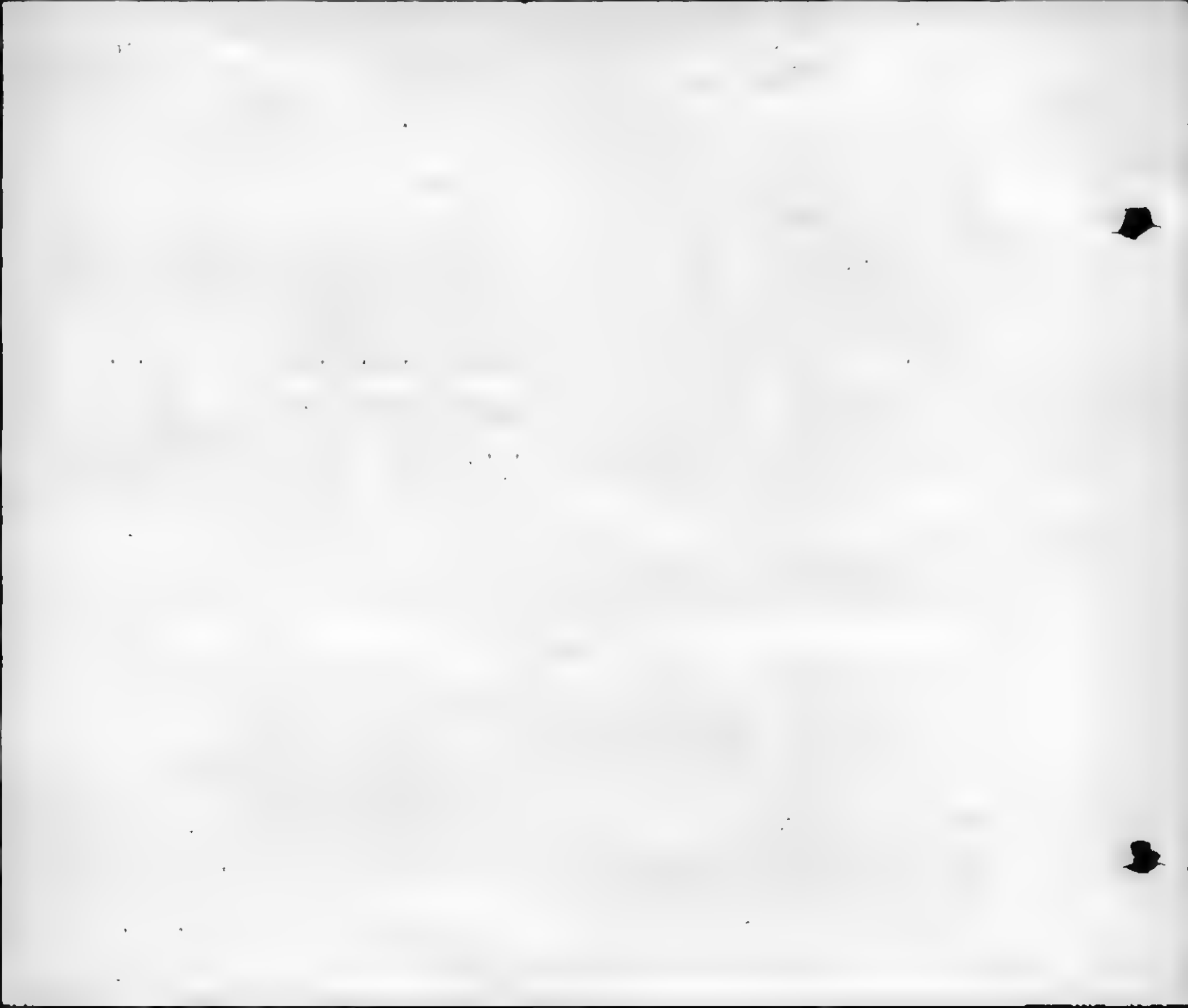
Reg. Dist. No. 02853

2871

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pikesville		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 301 Church Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eliza Maude Watts		4. DATE OF DEATH March 20, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1889
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pikes. 5&10		10b. KIND OF BUSINESS OR INDUSTRY Merchandise	
11. BIRTHPLACE (State or foreign country) Baltio. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Keck Pearce		14. MOTHER'S MAIDEN NAME Annie Eliza Gray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 219-22-4454	
17. INFORMANT Mr. M. Pearce Watts		Address Pikesville 8, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure - Chronic DUE TO (c) Arteriosclerosis - generalized		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1957 to March 20, 1961 , that I last saw the deceased alive on March 17, 1961 , and that death occurred at 12:42 P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE Clarence E. McWilliams		DATE SIGNED March 20, 1961	
PHYSICIAN'S NAME (Type) Clarence E. McWilliams		ADDRESS (Street, city or town, state) 11904 Reisterstown Rd., Reisterstown, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 23, 1961	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville 8, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Howell		ADDRESS 8714	
24a. REC'D BY REGISTRAR 42.31		24b. REGISTRAR'S SIGNATURE Arthur S. Kram	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2872

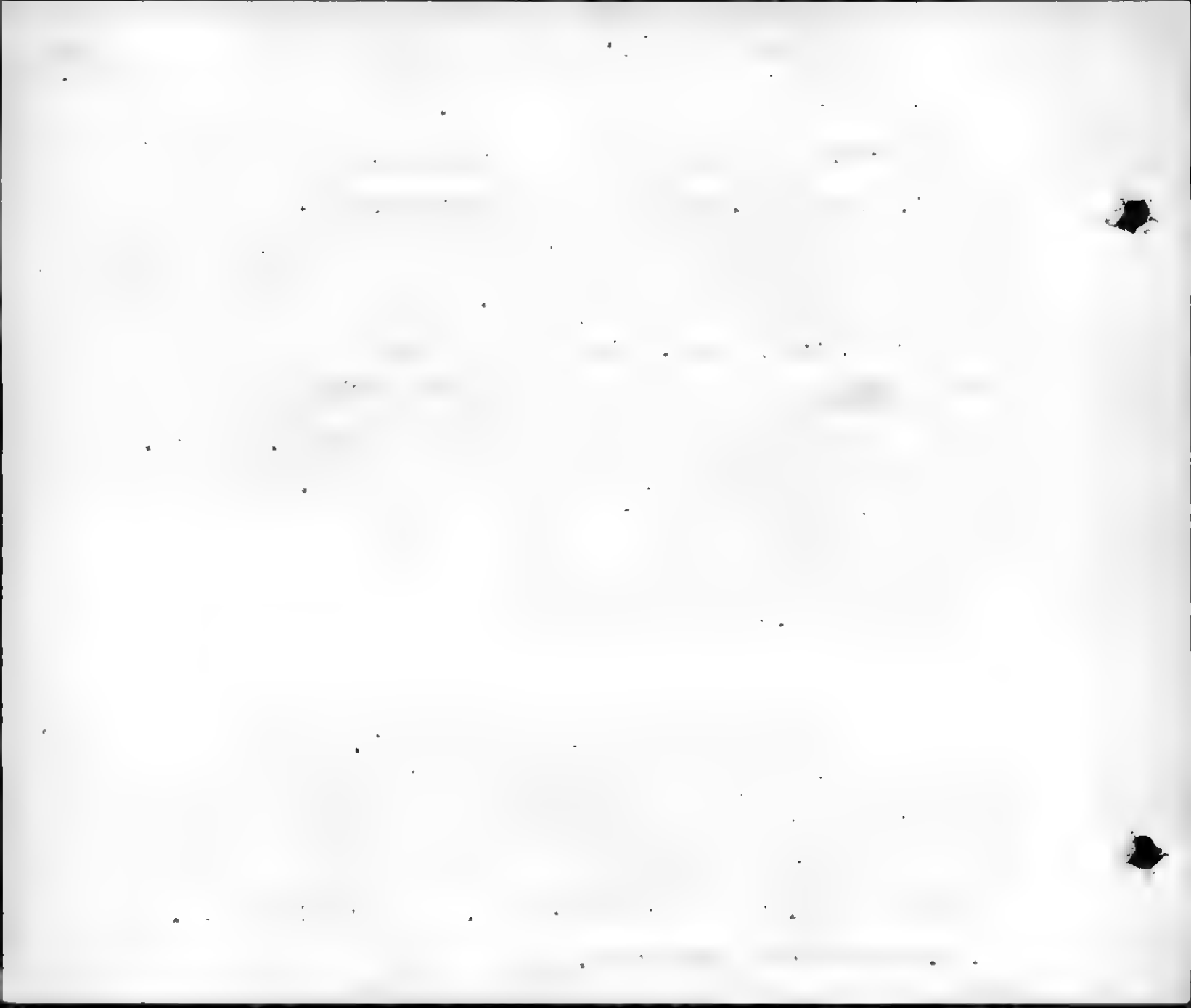
CERTIFICATE OF DEATH

Reg. Dist. No. 02854

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Joseph Nur. Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Daisy A. Weber		4. DATE OF DEATH March 10 61	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1882
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) Cashier (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Hoch. Kohn	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Otto Weber		14. MOTHER'S MAIDEN NAME Sarah Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)	
INFORMANT Brother		Address 1625 E. 32nd St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 1999X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterioscl. cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH 3 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 19, 1961 to March 10, 1961 , that I last saw the deceased alive on March 10, 1961 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Justinas Kupirka M.D.		ADDRESS (Street, city or town, state) 1709 Edmonson ave, B. H. C. I	
PHYSICIAN'S NAME (Type) Justinas KUPIRKA		City, town, or county (State) Catonsville, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/13/ 61	22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cem.	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. BURIAL DIRECTOR'S SIGNATURE P. A. Heemann		ADDRESS 6067 Harford Rd.	
24a. REC'D BY REGISTRAR MAR 16 '61		24b. REGISTRAR'S SIGNATURE Charles S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2873

02855

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN b. <u>2532 Windsor Road</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2532 Windsor Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>231</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>2532 Windsor Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Basil</u> First Middle Last <u>Smith "Wellener, Jr."</u>		4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1961</u>		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>2-7-1880</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR Months <u>3</u> Days <u>26</u> IF UNDER 24 HRS. Hours <u>19</u> Min. <u>61</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Assemblyman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Bendix Corp.</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Basil S. Wellener, Sr.</u> 14. MOTHER'S MAIDEN NAME <u>Kate W. Hamill</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>215070654A</u> 16. SOCIAL SECURITY NO. <u>Elenora Wellener</u> 17. INFORMANT <u>same</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> (b) <u>arterio-sclerotic Cardio Vascular</u> (c) <u>Arterio-sclerotic Cardio Vascular</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-sclerotic Cardio Vascular</u> (b) <u>Arterio-sclerotic Cardio Vascular</u> (c) <u>Arterio-sclerotic Cardio Vascular</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21 I certify that (I) (this hospital) attended the deceased from <u>24 Jan 1961</u> to <u>26 March 1961</u> that (I) (we) last saw the deceased alive on <u>25 March 1961</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Charles W. Edmonds</u> 22b. DATE SIGNED <u>27-March-1961</u> 22c. PHYSICIAN'S NAME (Type) <u>Charles W. Edmonds</u> 22d. ADDRESS <u>2746 The Alameda</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>3-29-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u> 23d. LOCATION (City, town or county) <u>Baltimore, Md.</u> (State)					
24 FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> 25a. REC'D BY REGISTRAR <u>DATE MAR 29 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>					

MEDICAL CERTIFICATION



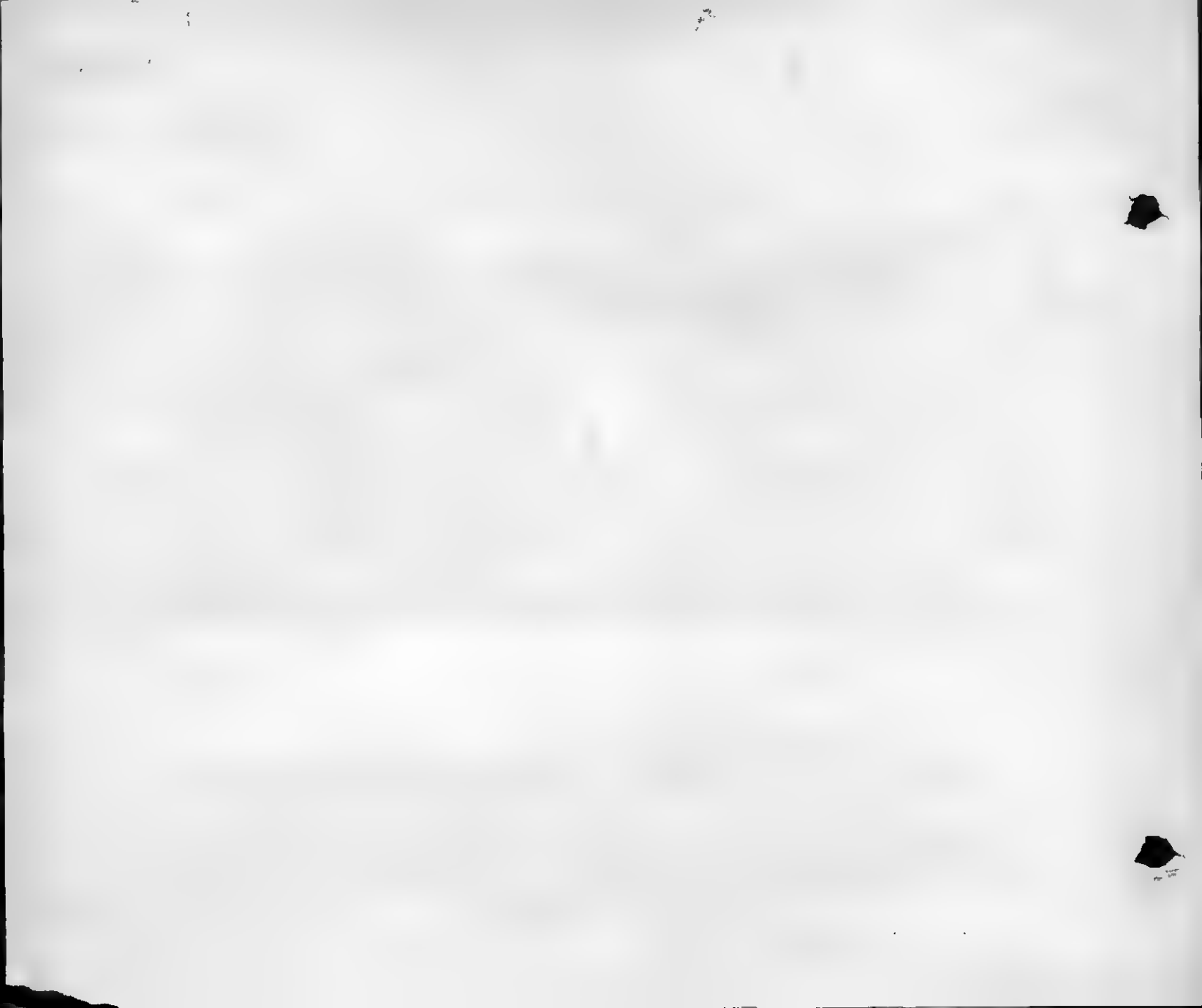
TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is not a resident of the State, the certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 11/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2874 CERTIFICATE OF DEATH

02856

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hosp'te, give street address) <u>Shady Nook Conv. Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>237 Rollingbrook Way</u> e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) <u>Mollie P. Welsh</u> First Middle Last 4. DATE OF DEATH <u>March 10 1961</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 11, 1875</u> Yrs. Months Days Hours Min.	
9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Stevens</u> 14. MOTHER'S MAIDEN NAME <u>Brace</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Mr. Spencer Welsh</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> <u>2 mos.</u> <u>15 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-21-1961</u> to <u>3-10-1961</u> , that (I) (we) last saw the deceased alive on <u>3-10-1961</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Wilbur K. Gallagher</u> M.D.		22b. DATE SIGNED <u>3-13-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wilbur K. Gallagher, M.D.</u>		22d. ADDRESS <u>6209 Lindenwood, Balt. 28, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/13/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		23d. LOCATION (City, town or county) (State) <u>Howard Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Duff & Son</u> ADDRESS <u>28</u>		25a. REC'D BY REGISTRAR <u>MAR 14 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1802857

WESTERNMAN

CERTIFICATE OF DEATH

3201 Tyndale
Reg. Dist. No. Balto City

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>9 1/2 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6811 Campfield Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>BARBARA</u> Last <u>WESTERMAN</u>		4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 18, 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, ever if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>
13. FATHER'S NAME <u>Frederick KOWALLER</u>		14. MOTHER'S MAIDEN NAME <u>Luella Reisinger</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>5th Katerkampfs 6811 Campfield</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) - Broncho-Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(2) Arterio-Sclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arterio Sclerotic Heart</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio Sclerotic Heart</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> 19 <u>56</u> , to <u>March 8</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 7-1961</u> , and that death occurred at <u>3:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl L. Chambers</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>4108 Liberty Hts Ave. Balto. Md. 3-8-61</u>	
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers - m.d.</u>		<u>4108 Liberty Hts. Balto-Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-11-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Saint Paul's Lutheran Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>David Hill Rd. Coed. Trd.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Mullin Jr. - 2431 E. Olney St.</u>		24a. REC'D BY REGISTRAR <u>MAR 13 '61</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>

I

MEDICAL CERTIFICATION



2876

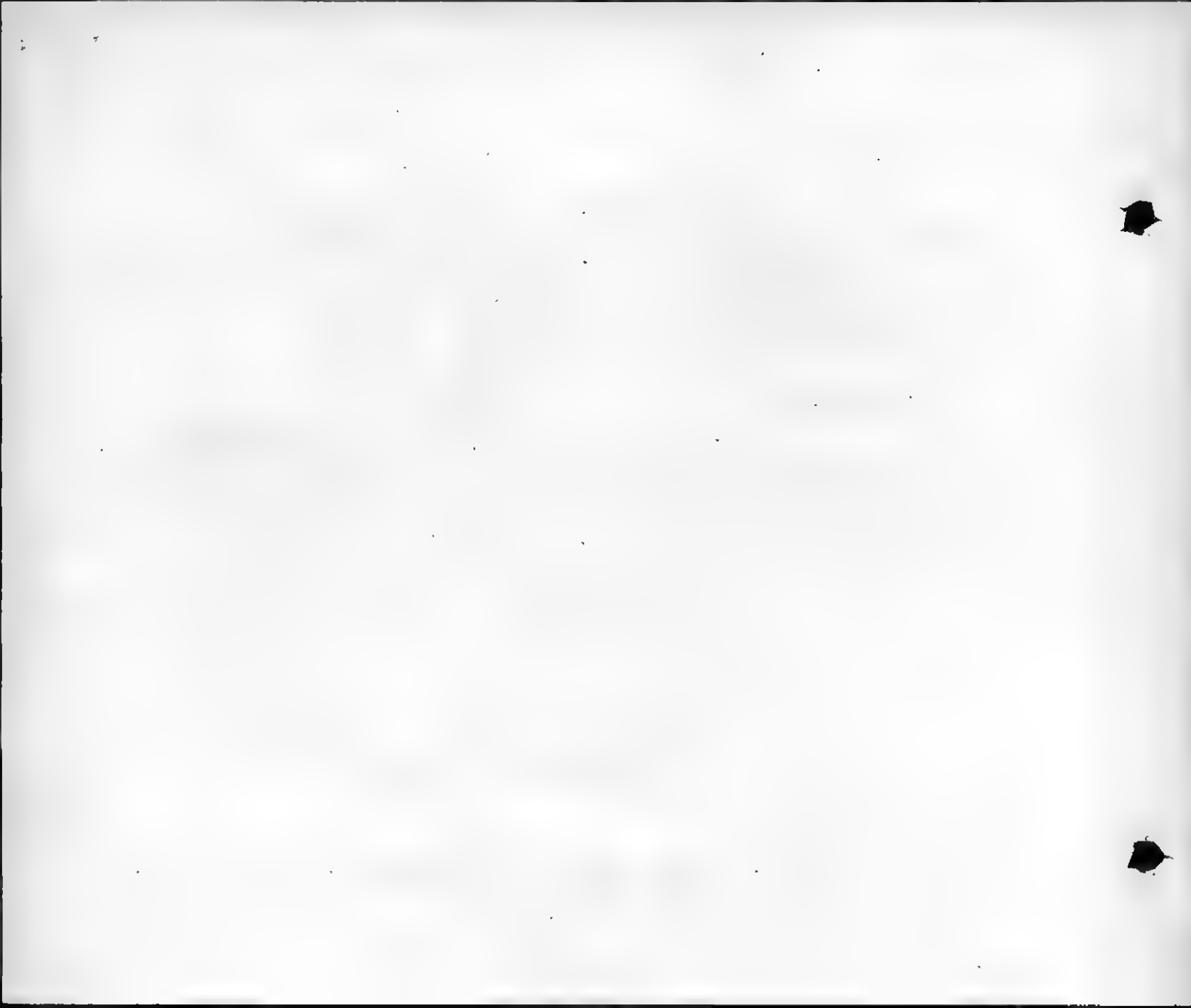
CERTIFICATE OF DEATH

Reg. Dist. No. 02858

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b X Dickeyville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home				d. STREET ADDRESS 15002 Wetheredsville Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLORENCE Middle A. Last WETTSTEIN				4. DATE OF DEATH Month March Day 6 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 25, 1885	
9. AGE (In years lost birthday) 75 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Delmont Angel				14. MOTHER'S MAIDEN NAME Atta Roat			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 391-24-7894		INFORMANT Mrs. Ruth W. Carter-5608 Dogwood Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Carcinoma of breast c metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 11 days 25 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/20 , 19 57 to 3/6 , 19 61 , that I last saw the deceased alive on 3/2 , 19 61 , and that death occurred at 2 1/2 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3408 Windsor Ave. DATE SIGNED 3/7/61							
ACTUAL SIGNATURE Robert A. Reiter		M.D. 3408 Windsor Ave.					
PHYSICIAN'S NAME (Type) ROBERT A. REITER, M.D.		Garrison Blvd. & Windsor Ave.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/1961		22c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		22d. LOCATION (City, town, or county) (State) Woodlawn Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost-4600 Liberty Hghts. Ave.				24a. REC'D BY REGISTRAR DATE MAR 9 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kross	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be filled by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

02859

2877

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills.</u>	
c. LENGTH OF STAY IN 1b <u>20yrs.</u>		d. STREET ADDRESS <u>1 Cradock Lane</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cradock Lane</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hazel</u> Middle <u>Wilhelm</u> Last <u>Wilhelm</u>		4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 5, 1900</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR: Months <u>60</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>White Hall, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Holloway</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Hammer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mollie Wilhelm</u>		Address <u>Owings Mills, Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

331X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

7 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Former cerebral thrombosis & paralysis

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m.20d. INJURY OCCURRED
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 3/19, 1961, to 3/29, 1961, that I last saw the deceased alive on 3/29, 1961, and that death occurred at 5:45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE

Grace G. Jones

M.D.

17 Walker Avenue

DATE SIGNED

3/30/61

PHYSICIAN'S NAME (Type)

Dr. Grace G. JonesBaltimore 8 - Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

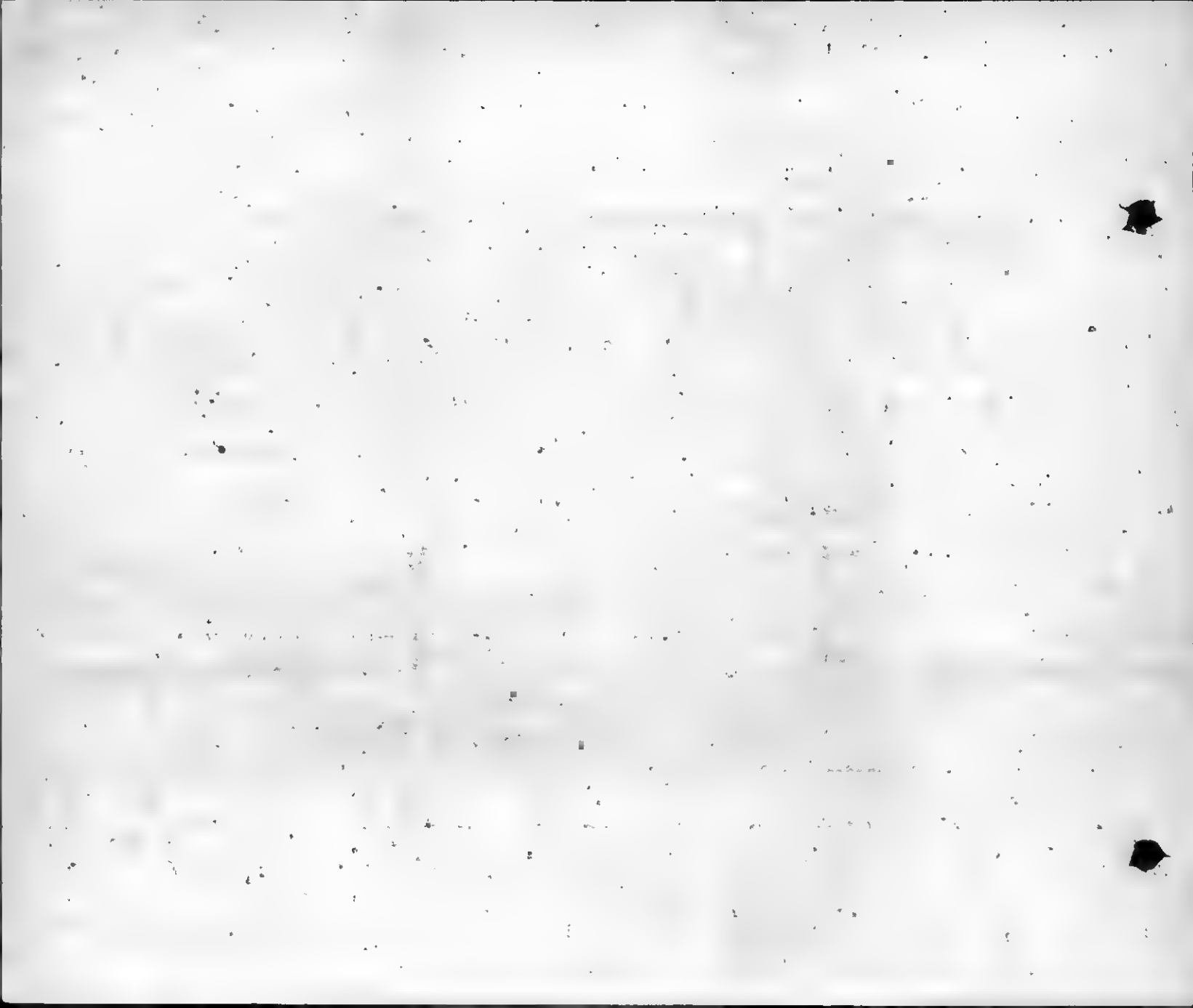
ADDRESS

24a. REC'D BY-REGISTRAR

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

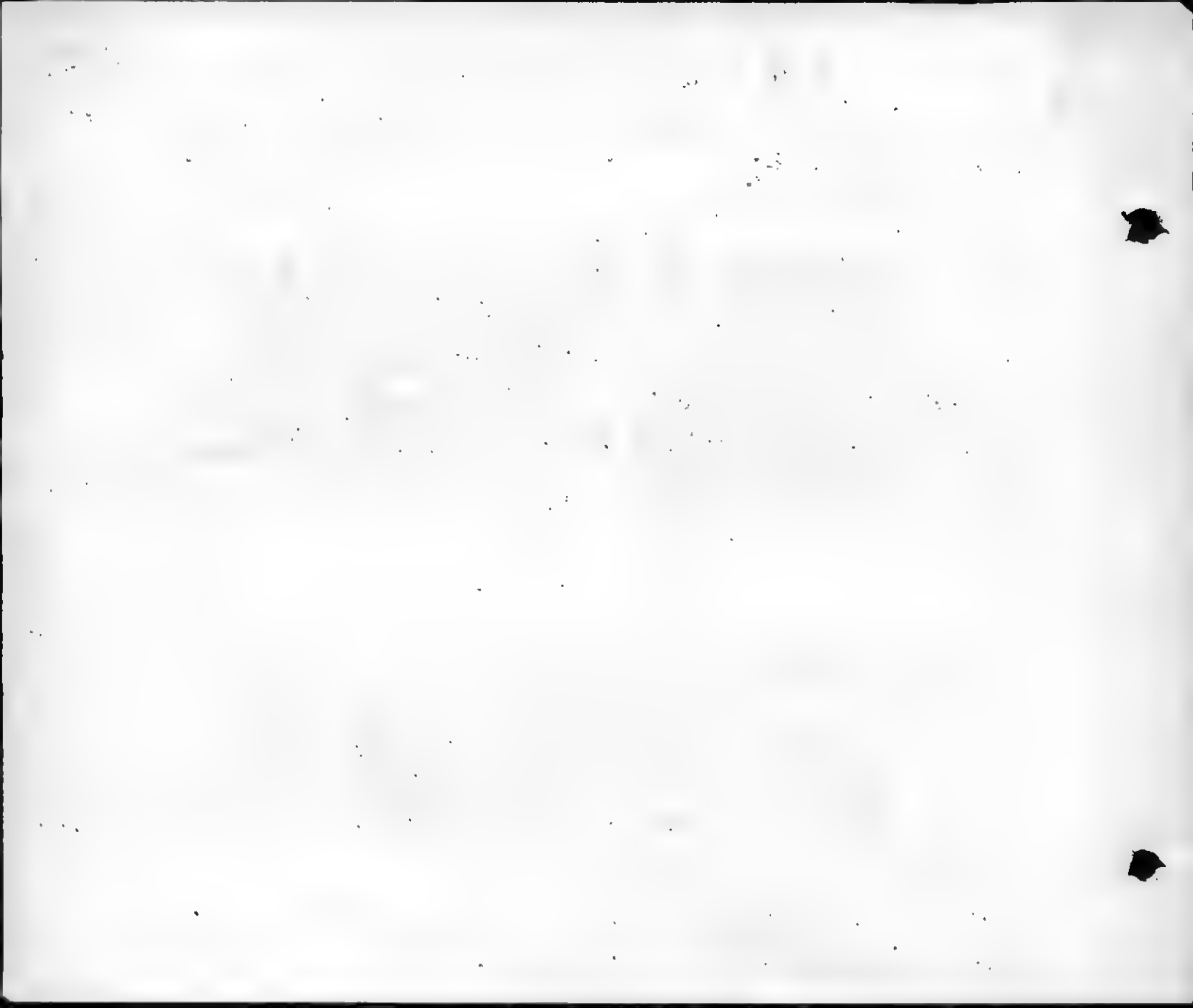
Reg. Dist. No. 02860

2878

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>		c. LENGTH OF STAY IN 1b <u>25 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old York Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virginia C. Wineholt</u>		4. DATE OF DEATH <u>March 2, 1961</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 1, 1904</u>
9. AGE (In years last birthday) <u>56</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sewing Factory Petersburg, W. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Cameron Cochran</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hutton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>168-143912</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 7-0-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Arterio-sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> m. <input type="checkbox"/> p. m. 19 <u>61</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 2, 1961</u> to <u>March 2, 1961</u> , that I last saw the deceased alive on <u>March 2, 1961</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. M. France</u> M.D.		ADDRESS (Street, city or town, state) <u>PARKTON, Md.</u> DATE SIGNED <u>3/4/61</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 5, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Freedom Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>New Freedom Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u> ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>MAR 7 '61</u>	24b. REGISTRAR'S SIGNATURE <u>John S. Kneiss</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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M
X
O
1

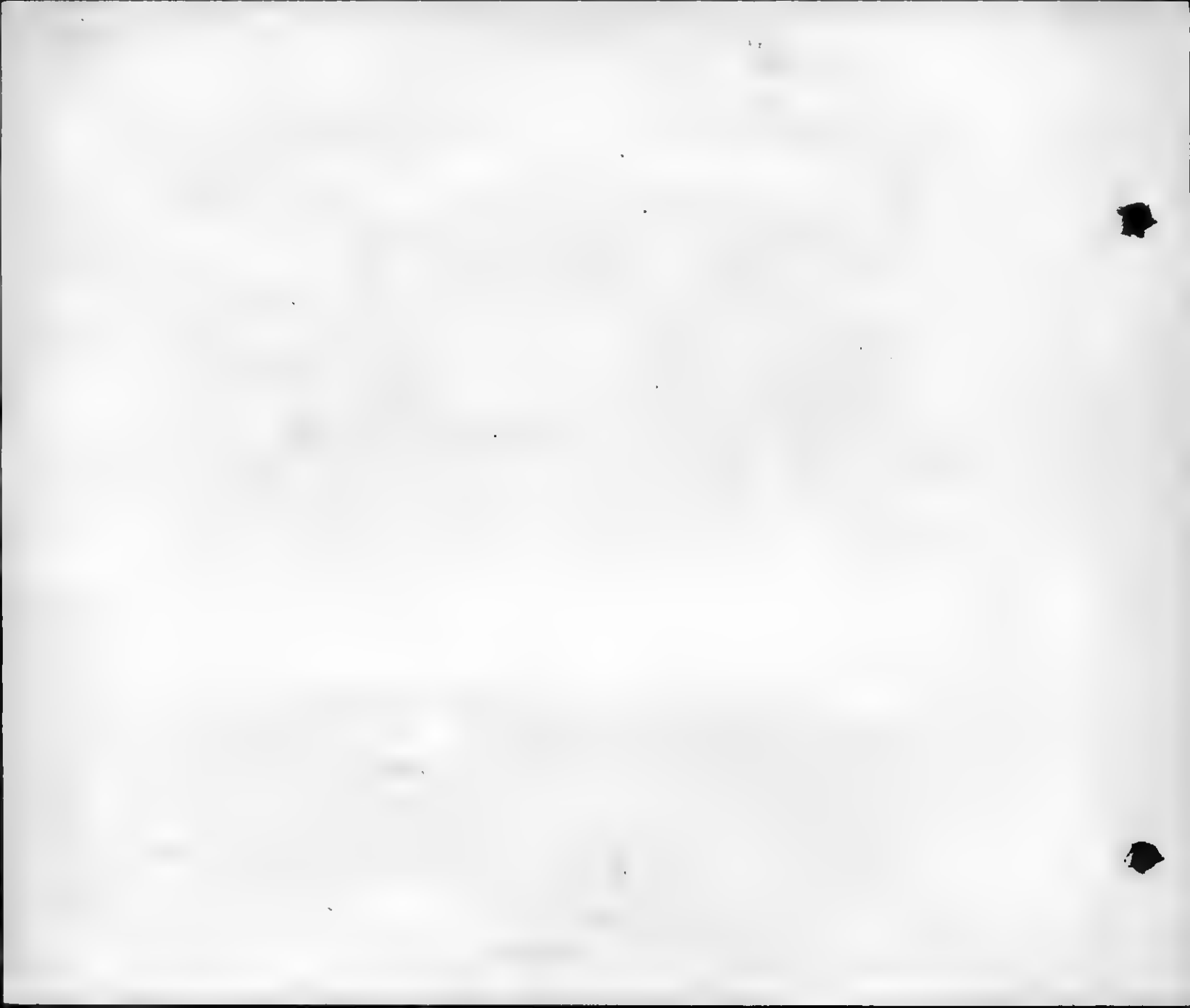
2879

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02861

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
c. LENGTH OF STAY IN 1b <i>1 yr.</i>				d. STREET ADDRESS <i>6215 Norvo Rd.</i>			
d. NAME OF HOSP TAL (If not in hospital, give street address) OR INSTITUTION <i>6215 Norvo Rd.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Louis Wolf Wolfe</i>				4. DATE OF DEATH <i>Mar. 18 1961</i>			
5 SEX <i>Male</i>		6 COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 18, 1891</i>	
9. AGE (in years last birthday) <i>69</i> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>tailor</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>shop</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Jacob Wolfe</i>				14. MOTHER'S MAIDEN NAME <i>Saga ?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <i>_____</i>		17. INFORMANT <i>Blanche Wolfe</i> Address <i>Same</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of lung with metastases to kidney</i> DUE TO (b) <i>163X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21 I certify that (I) (this hospital) attended the deceased from <i>2/1/61</i> 19 to <i>3/18/61</i> 19, that (I) (we) last saw the deceased alive on <i>3/10/61</i> 19, and that death occurred at <i>10 AM</i> , from the causes and on the date stated above							
22a. SIGNATURE <i>Milton Schleroff</i>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>Milton Schleroff</i>				22d. ADDRESS <i>6410 Windsor Mill Rd.</i>			
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3/19/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Karnath Israel</i>		23d. LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Sal Leunior & Bros Inc</i>				25a. REC'D BY REGISTRAR <i>6010 Reisterstown Rd.</i>		25b. REGISTRAR'S SIGNATURE <i>O. Elmer S. Kraus</i>	



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2880

CERTIFICATE OF DEATH

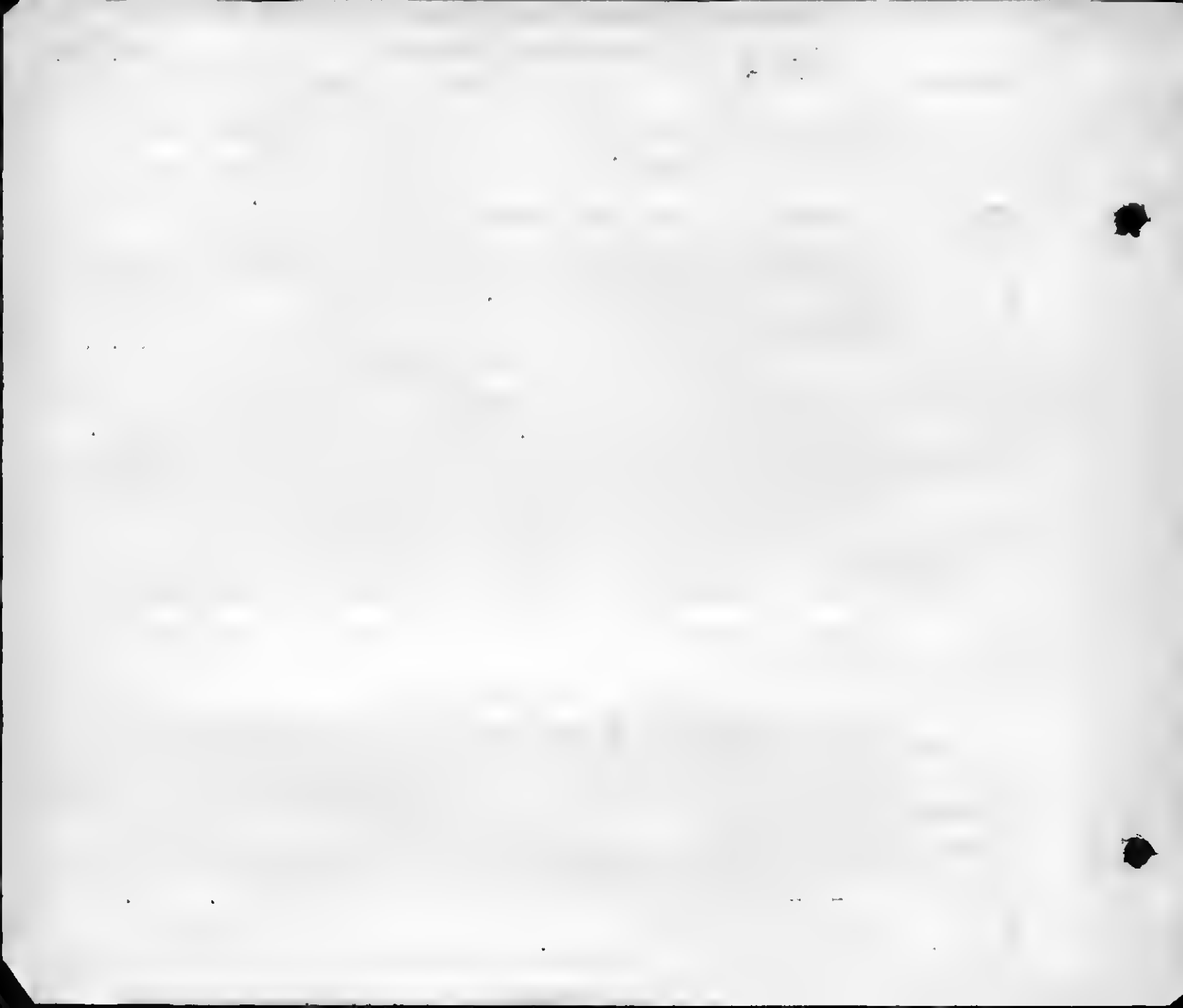
Reg. Dist. No. 02862

1. PLACE OF DEATH o COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.S., 1924 Haselmere Road		d STREET ADDRESS 1924 Haselmere Rd.	
3. NAME OF DECEASED (Type or print) First GLORA Middle WOODARD Last WOODARD		4. DATE OF DEATH Month March Day 24 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17, 1900
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Dodson		14. MOTHER'S MAIDEN NAME Alice Leake	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. Julia Brady		Address 1924 Haselmere Rd. 22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis 1701 DUE TO CA. of Gall Bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) unknown (c)		INTERVAL BETWEEN ONSET AND DEATH 9 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malnutrition		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 Feb 1961 to 24 Mar 1961 , that I last saw the deceased alive on 23 Mar 1961 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Morrison M.D.		ADDRESS (Street, city or town, state) 3 Kinship Rd Dundalk 22 Md.	
DATE SIGNED 23 Mar 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3-27-1961	
22c. NAME OF CEMETERY OR CREMATORY Loucon Park		22d. LOCATION (City, town, or county) (State) Frederick Rd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		ADDRESS 7922 Wise Ave, 22, Md.	
24a. REC'D BY REGISTRAR DATE MAR 28 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02863

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rowley's Quarters		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rowley's Quarters	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Clarks Point Rd.		d. STREET ADDRESS Clarks Point Rd.	
3. NAME OF DECEASED (Type or print) Maude First Edwina Middle York Last		4. DATE OF DEATH March 29 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1884
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown McElroy		14. MOTHER'S MAIDEN NAME Unknown Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Vol. no. or unknown) No		16. SOCIAL SECURITY NO. 217-22-8443	
17. INFORMANT Mrs. Milton R. Stewart		Address Box 79 Rt. 15 (20)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-Vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1961, to March 29, 1961, that I last saw the deceased alive on March 29, 1961, and that death occurred at 2:25 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. M. Baumgardner M.D.		ADDRESS (Street, city or town, state) Balto 6 Md	
DATE SIGNED 3/29/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-1-1961	
22c. NAME OF CEMETERY OR CREMATORY Ebenezer		22d. LOCATION (City, town, or county) (State) Chase, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Funeral Home		ADDRESS 7461 Belair Rd.	
24a. REC'D BY REGISTRAR DATE APR 3 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2882

02864

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>Catonsville</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jan F. Young</u>				d. STREET ADDRESS <u>2 1/2 Dutton Ave</u>			
4. DATE OF DEATH Month Day Year <u>3 11 1961</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/22/10</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto mfg. - Motor Transport</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Wet. India</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Neil F. Young</u>				14. MOTHER'S MAIDEN NAME <u>Mackay</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>1081-09-8954</u>			
17. INFORMANT <u>Wm. E. Howard</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterial Hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>1 year</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 15</u> , 19 <u>57</u> to <u>March 11, 1961</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>March 11</u> , 19 <u>61</u> , and that death occurred at <u>11:55 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John A. Nesbitt Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-13-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR.</u>				22d. ADDRESS <u>1118 St Paul St., Baltimore 2, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>3/14/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. E. Howard</u>				ADDRESS <u>28</u>		25e. REC'D BY REGISTRAR <u>MAR 14 61</u>	
						25b. REGISTRAR'S SIGNATURE <u>William E. Howard</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2883 CERTIFICATE OF DEATH

02865

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Putty Hill		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Putty Hill	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7922 Rolling View Road		d. STREET ADDRESS 7922 Rolling View Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JUSTINE Middle ZOLMAN Last		4. DATE OF DEATH Month March Day 22 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1883
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wunder		14. MOTHER'S MAIDEN NAME Catherine Ziprick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. John Raschka 1409 Vesper Ave.-22		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis acute 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis, chronic DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 mos 1 yr. 2 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1945 to Mar 22, 1961 , that (I) (we) last saw the deceased alive on Mar 21, 1961 , and that death occurred at 7 A.M. from the causes and on the date stated above.			
22a. SIGNATURE David H. Andrew		22b. DATE SIGNED 3/23/61	
22c. PHYSICIAN'S NAME (Type) David H. Andrew		22d. ADDRESS 33 Dundalk Ave Dundalk Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 25, 1961	
23c. NAME OF CEMETERY OR CREMATORY Christ Lutheran Cemetery		23d. LOCATION (City, town, or county) (State) Dundalk, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.,		25a. REC'D BY REGISTRAR DATE MAR 27 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. H...			

20300

RECEIVED

1922

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TO THE HONORABLE SECRETARY OF THE
NAVY
WASHINGTON, D. C.
DEAR SIR:
I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the above subject.
The same has been forwarded to the proper authorities for their consideration.
Very respectfully,
Yours truly,
[Signature]